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RESTRICTING MEDICAL LICENSES BASED ON ILLNESS IS WRONG - REPORTING MAKES IT WORSE

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A physician from a Midwest state suffers a depressive illness which causes him distress but in no way impairs his ability to practice medicine. He seeks psychiatric care and is successfully treated with a combination of psychotherapy and antidepressant medication.

He moves to a Southern state, applies for a license, and passes the examination. In response to a question on the Southern state's application, he discloses his treatment for depression. The board of the Southern state requires he join the impaired physician program. The board concedes his illness does not now, nor did it ever, adversely affect his ability to practice medicine with skill and safety, but imposes periodic "monitoring" as a condition to practice. He accepts the restricted license in the Southern state because, while it is a nuisance, his ability to practice with skill and safety is not compromised.

This license restriction is reported to data banks or revealed during the Midwest state's renewal process. Based on the Southern state's restriction, his renewal application is denied, and his license to practice medicine in the Midwest state is suspended.

Something is wrong with the system.

What is wrong is boards consider illness, rather than functional impairment, as a factor in determining both competence to practice and license restrictions.

Boards are charged with the duty to protect patients from incompetent physicians. To meet that duty, boards claim they need to know about a doctor's mental illness or substance abuse. Although medical data does not support this claim, previous challenges failed because of an inability to overcome the presumption that presence of mental illness or substance abuse is rationally related to competence to practice. Some courts have recognized doctors possess limited property and liberty interests in their profession; *(See, e.g., Hirsch v. N.J. State Bd. of Medical Examiners, 600 A.2d 493 (N.J. Super. 1991) aff'd 607 A.2d 986 (1992). A licensed physician and two state medical societies challenged questions-including inquiries about mental illness and substance abuse-on the New Jersey biennial license renewal application. The court reviewed recent state legislation enacted to encourage physicians to*

obtain treatment and to permit boards to deal with impaired physicians. Interpreting the questions as attempts to determine whether the physician is impaired, the court said a medical license "'is not a basic individual right. While it embraces a substantial individual interest which deserves abundant protection, it cannot be equated with a fundamental right, the reasonable regulation of which can be measured and justified only by a compelling state interest.'" Id. at 497, quoting In re Polk, 449 A.2d 7 (N.J. 1982). Nevertheless, the court recognized that the board could not achieve its legitimate purpose of identifying impaired physicians by violating a licensee's constitutional rights. Id. at 497-99.) however, additional inquiries *(Similar questions arise about inquiries concerning history of mental illness or substance abuse on professional license applications. See generally Phyllis Coleman and Ronald A. Shellow, Ask About Conduct, Not Mental Illness: A Proposal for Bar Examiners and Medical Boards to Comply with the ADA and Constitution, 20 J. OF LEGIS. 147 (1994). That issue is beyond the scope of this article.)* and license restrictions based on illness have survived if boards provided procedural due process.(But see Timothy Stolzfus Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 HOUSTON L. REV. 525, 587 (1988) suggesting boards might provide doctors too much protection causing increased risks to their patients. "Layer on layer of due process has been provided professionals, reflecting the high regard accorded the precious professional license, yet largely disregarding the threat incompetents pose to the lives and health of their patients.") Courts have also used a balancing test to reject arguments based on the physician's privacy rights. (See infra notes 58-67 and accompanying text.)

Results should be different under the Americans with Disabilities Act (ADA), (42 U.S.C. ~ 12101 et seq. (Supp. 1994).) passed to prevent discrimination against sick people. Because Congress elevated people with disabilities to suspect class status, board procedures for imposing restrictions based on illness must now survive strict scrutiny. Boards can easily satisfy the first part of this test by demonstrating a compelling state interest in protecting the public from incompetent physicians. However, license restrictions based on illness fail the second part of the test: absent proof of a sufficient link between history of illness or addiction and competence to practice, license restrictions based solely on sickness are simply not narrowly tailored to effectuate the concededly compelling state interest in protecting the public from bad doctors.

In fact, when boards treat restrictions based on illness the same as those resulting from conduct demonstrating or foreshadowing substandard practice, they not only violate the ADA, they lose sight of their objective. Boards sincerely interested in identifying bad doctors should shift their focus from illness to behavior. (See infra notes 124-30 and accompanying text.)

Flawed board practices are further complicated by comprehensive reporting requirements. All restrictions, whether based on competence or illness, are reported or available to centralized data banks and other state boards. This means, even if a physician's ability to practice is never impaired, a state might improperly deny his application or suspend his license because of another state's illness-based restriction. Ironically, by mandating all restrictions be reported, the system actually encourages decisions based on irrelevant license limitations, and permits boards to sidestep the difficult task of identifying incompetent physicians.

Part I of this article briefly explores the licensing and disciplinary processes. Because each state board has broad discretion in reaching its decisions, (Kathleen L. Blaner, Comment, Physician, Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse than the Disease, 37 CATH. U.L. REV. 1073, 1079-80 (1988) [hereinafter Physician, Heal Thyself].

Physicians are licensed through state boards composed primarily of other doctors. See, e.g., Coe v. United States Dist. Ct. for Dist. of Colo., 676 F.2d 411, 414 (10th Cir. 1982) explaining the Colorado State Board of Medical Examiners has nine physician members and two from the public at large. The general presumption has been that physicians are the best judges of their peers. Harold L. Hirsh, The Medical-Legal Implications of the Errant or "Sick" Physician, 1976 MED. TRIAL TECH. Q. 377.

In fact, as far back as 1760, the colonies established boards to license qualified physicians. Their primary responsibilities were licensing and disciplining doctors. Each state retains discretion to decide standards for licensure. Generally, boards sanction physicians for conduct which is harmful or involves moral turpitude. Physician, Heal Thyself, supra note 9, at 1078-80) an illness might be ignored in one state, trigger only periodic monitoring in another, and be grounds for sanction in a third. As the duty of every state board is the same-to protect patients from incompetent doctors-this disparate treatment is absurd. The implicit notion that the impact of a physician's illness on his ability to practice changes depending on a state line is not credible. Although statutes and cases (The traditional malpractice standard depended on the reasonable physician in his geographic area. Thomas E. Dvorak, Board Certification and Summary Judgment Under the Idaho Medical Malpractice Act: Traps for the Unwary, 29 IDAHO L. REV. 421, 423-24 (1992-93). However, this does not support similar distinctions in license restriction decisions.

Further, the malpractice rule is changing. Some jurisdictions currently apply a national standard in recognition of "the uniformity of medical training and the almost instantaneous availability of medical information throughout the country." Id. at 425. Moreover, although it may still be possible to argue the availability of different technological and human resources could make a national malpractice standard unfair or unworkable, the same is not true for impact of illness on ability to practice.) may use different language to define incompetence, there is fundamental agreement that doctors in every state should practice with skill and safety.

Part II exposes fundamental defects in the current reporting to national data banks. The goal of preventing incompetent physicians from injuring a series of uninformed patients in several states is commendable. Implementation is not.

For example, to comply with the Health Care Quality Improvement Act's (HCQIA) requirement to report any action which "revokes or suspends (or otherwise restricts) a physician's license ... ," (42 U.S. C. ~ 11132(a)(1)(A) (1995).) boards might inappropriately report restrictions such as monitoring medication or participating in a substance abuse program. But, simply not reporting doctors (Before the National Practitioner Data Bank, the "only national resources for collecting data on individual physicians have been the Federation of State Licensing Boards, which provides a clearinghouse for state

disciplinary actions, and the AMA's Masterfile, which records essential data on each physician, starting with his enrollment in any U.S. program of medical training. The Masterfile also alerts state regulators to disciplinary actions in other states and responds to inquiries by hospitals (250,000 in 1985)." CLARK C. HAVIGHURST, HEALTH CARE LAW AND POLICY 402 (1988). However, neither maintains the wide range of material in the National Practitioner Data Bank.

In fact, commentators claim one explanation for "why incompetent physicians, though arguably few in number, pose such a significant threat" to good health care is their ability to simply move to another state and open a practice. Without a national comprehensive reporting system, boards had "no thorough way of uncovering" malpractice and disciplinary histories. Charity Scott, Medical Peer Review, Antitrust, and the Effect of Statutory Reform, 50 MD. L. REV. 316, 325 (1991).) who participate in an impaired physician's program is insufficient. Because involvement in a program might be unrelated to impairment, monitoring and absence of confidentiality mean this option may unnecessarily infringe upon a doctor's right to privacy and violate the ADA without helping protect the public from incompetent physicians.

In fact, because the HCQIA requires entities report only actions related to "professional competence or professional conduct," (42 U.S.C. ~ 11132(a)(1)(A) (1995).) illness-based restrictions need not be disclosed. No evidence exists to support the inference that a doctor's "professional competence or professional conduct" is compromised merely because he either suffers from a disorder which requires medication or battles an addiction.

The Federation of State Medical Boards (This national organization includes the licensing and disciplinary medical boards from all 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Medicare and Medicaid Patient and Program Protection Act of 1984: Hearings on H.R. 5989 Before the Subcomm. on Health of the House Comm. on Ways and Means, and the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 98th Cong., 2nd Sess. 54 (1984) (Statement of Bryant L. Galusha, Exec. Vice-President and Chief Operating Officer, Federation of State Medical Bd.)) also collects licensure data. But, the Federation records and distributes all actions, not only those related to professional competence. (Fitzhugh Mullan et al., The National Practitioner Data Bank Report From the First Year, 268 JAMA 73, 76 (1992).)

Part III explains that the Americans with Disabilities Act prohibits treating persons with disabilities-or even those "regarded as" disabled-differently solely because of their illness. In imposing and reporting illness-based restrictions, without evidence of impairment, boards violate the ADA by discriminating against people based on their sickness.

Part IV reviews a few particularly egregious board decisions. These cases illustrate board prejudice against doctors suffering from mental illness or past substance abuse. Because these boards fail to distinguish between sickness and impairment, their conclusions are not only incorrect, they violate the ADA.

Part V explores an inherent flaw in the current system. Regardless of their ability to practice with skill and safety, sick doctors may be referred to impaired physician programs. Doctors, who should know better, confuse illness with impairment.

Finally, this article proposes a simple solution to comply with the ADA while achieving the boards' duty to protect the public and prevent incompetent doctors from moving to another state and injuring unsuspecting patients. Boards should only impose restrictions which involve the physician's "professional competence or professional conduct." This would also mean that the only restrictions reported would be those based on incompetence or misconduct.

I. MEDICAL BOARDS

Medical boards face the difficult but essential task of protecting the public from incompetent physicians. Indeed, licensing boards "are widely, if dimly, perceived as the keepers of the gate of the medical profession." (Timothy S. Jost et al., Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards, 3 HEALTH MATRIX 309, 338 (1993) [hereinafter Consumers, Complaints, and Professional Discipline].) Boards discharge this responsibility at four critical stages of the process: 1) Initial license, 2) license renewal, 3) disciplinary proceedings, and 4) license application in one state by a physician previously licensed in a different state. Unfortunately, many boards still use history of mental illness or substance abuse to reach decisions at each point.

A. Initial License

More than one hundred years ago, the Supreme Court approved state authority to regulate who may practice medicine (Dent v. West Virginia, 129 U.S. 114 (1888).) In exercising their power "to provide for the general welfare," states may impose requirements "appropriate to the calling or profession, and obtainable by reasonable study or application." (Id. at 122.) States delegate their regulatory duty to agencies or boards. (Jesse A. Goldner, An Overview of Legal Controls on Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously, 38 ST. LOUIS U.L.J. 63, 66 (1993). Whether the system "works," by meeting "society's goals of improving the quality of medical services, disciplining professionals, and preventing the non-licensed practice of medicine" is an "open" question. Id.

Challenges to such delegation have been repeatedly rebuffed. See, e.g., Douglas v. Noble, 261 U.S. 165 (1923)) These boards are granted broad deference, but criteria (Citizenship and residency requirements have been successfully challenged and eliminated, but character and fitness criteria are upheld. RANDOLPH P. REAVES, THE LAW OF PROFESSIONAL LICENSING AND CERTIFICATION 30-39 (1st ed. 1984). Unfortunately, some state boards inappropriately treat sickness as a character and fitness issue. Instead, although somewhat ambiguous, "'good moral character'" should be defined as including "simple honesty, fairness, respect for the rights of others, and for the law." Abrahamson v. Dept. of Professional Regulations, 568 N.E.2d 1319, 1324 (Ill. App. Ct. 1991).

Consent to mental and physical examinations if the board questions a doctor's ability to practice with skill and safety is a condition to licensure in a majority of states. Humenansky v. Minnesota Bd. of Medical Examiners, 525 N.W.2d 559, 563, n.1 (Minn. Ct. App. 1994). This means boards may order medical evaluations when they have probable cause to believe the physician poses a risk to patient safety. Id. at 562. "When a conflict arises between a physician's right to pursue a medical profession and the state's right to protect its citizenry, the physician's right must yield to the state's power to prescribe reasonable rules and regulations in order to protect the state's people from incompetent and unfit practitioners." Id. at 567.) imposed must have at least a rational relation to an applicant's fitness to practice. (Schware v. Board of Bar Examiners, 353 U.S. 232 (1957). The applicant in Schware was seeking a license to practice law rather than medicine. However, the principles are the same in all cases involving "professions requiring skill and learning prior to licensure." Reaves, supra note 20, at 2.)

While many diseases manifest in ways that could affect an applicant's competence to practice, license restrictions imposed to monitor illnesses do not necessarily involve competence. If boards want to protect the public from any doctor who truly poses an increased risk to his patients, they should only restrict the license of the physician whose behavior suggests monitoring is needed. The simple fact that a physician is ill and takes medicine on a regular basis should not be grounds for restriction. (Even HHS recognizes merely entering "a drug, alcohol, or psychiatric rehabilitation program" should not by itself be a reportable event. U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK 42 [hereinafter GUIDEBOOK]. This lends support to the argument that history of abuse should not constitute grounds for license restriction) Moreover, even if such a restriction is imposed, it should not be reported. (An ambiguity in the HCQIA casts doubt on whether such action was meant to be a reportable event. See infra notes 53-57 and accompanying text. The 1992 Supplement to the Guidebook provides examples of adverse licensure actions which "should not be reported." Unfortunately, one example actually increases the confusion:

* A settlement agreement which imposes monitoring of a practitioner for a specific period of time, unless such monitoring constitutes a re-striction of the practitioner's license or is considered to be a reprimand.

GUIDEBOOK 1992 Supplement 24. It is difficult to see how a board's monitoring would not "otherwise restrict" a doctor's license.)

B. License Renewal

In many states physicians must renew their licenses at prescribed intervals. (The value of relicensing varies depending on the rigor of the board's process.) This requirement helps licensing boards determine each doctor's continuing competence. (Licensing boards generally do not receive information concerning disciplinary actions by hospitals and malpractice payments in other states. Queries to the Data Bank as part of the license renewal process supply this potentially relevant information. U.S. DEP'T. OF HEALTH AND HUMAN SERVICES, OFFICE INSPECTOR GENERAL, NATIONAL PRACTITIONER DATA BANK, USEFULNESS AND IMPACT OF REPORTS TO STATE

LICENSING BOARDS ii-iii (March 1993) [hereinafter USEFULNESS AND IMPACT]. Further, even without querying the Data Bank, boards obtain a great deal of information as a result of the system created by the HCQIA. For example, all reports of malpractice payments made in a state are automatically sent to the board in that state. In addition, the Act makes boards the conduit for receiving reports of adverse actions from health care entities in their states and sending copies to the Data Bank.

Nevertheless, it is interesting to note that a 1993 study concluded that Data Bank responses provided new information to state boards, but none of the decisions would have been different without the reports. Id. However, conclusions based on this information are of limited value because the sample was too small to be meaningful.

In many states, laws also require reporting malpractice payments and hospital disciplinary actions. Adverse actions taken by other state boards against physicians are also reported. Id. at i. In some states, restrictions and participation in impaired physician programs are divulged in response to any inquiry.) A problem may occur when, during the relicensing process, a board discovers a physician's license has been restricted in another state. Although restrictions relating to "professional competence or professional conduct" (42 U.S.C. ~ 11132(a)(1)(A) (1995).) are relevant, those based solely on illness are not. Use of an illness-based restriction to reject a renewal application, revoke, or suspend a license is not only inappropriate, it violates the ADA. (See infra notes 68-97 and accompanying text.) If a board discovers during the relicensure process a physician suffers from some illness, it should issue an unrestricted license unless, based on the doctor's behavior, some limitation is necessary. (During the renewal process, imposing or reporting a restriction based only on illness probably violates the ADA. See infra notes 124-25 and accompanying text.)

C. Disciplinary Proceedings

As part of their duty to protect the public from incompetent physicians, (It is interesting to note that "[d]espite a general belief that medical licensure boards should play a major role in assuring the clinical competence of physicians, it is clear ... most disciplinary actions do not focus directly on issues of clinical competence." Consumers, Complaints, and Professional Discipline, supra note 16, at 332. In fact, in one study of 65 formal and informal board interventions, only six were directly based on improper clinical practices not involving prescribing controlled substances. Contrast this with the 11 interventions based, at least in part, on "physical or mental impairment of the practitioner (usually substance abuse)." Id.) boards sanction doctors who fail to practice medicine with skill and safety. (Sanctions may be imposed for some conduct unrelated to the practice of medicine. Raymond v. Board of Registration in Medicine, 443 N.E.2d 391, 394-95 (Mass. 1982). However, that does not mean a doctor's license may be restricted for medical conditions unrelated to practice. The difference is clear: boards may discipline doctors for conduct, not status. For example, the behavior of a physician convicted of a crime-even if not associated with his practice-calls his moral character into question. "Disciplining physicians for lack of good moral character, and for conduct that undermines public confidence in the integrity of the profession is reasonably related to promotion of the public health, welfare, and safety." Id. at 395.

Illness is different. No one would suggest a physician lacks good moral character simply because he suffers from cancer or heart disease. The same is true for mental illness and substance abuse. For example, in a lawyer licensing case, the New Jersey Supreme Court noted the cases "make clear that alcoholism is not a defect in character or personality." In re Strait, 577 A.2d 149, 157 (N.J. 1990). After conceding "alcoholism is a disease that adversely affects the exercise of good judgment and clear thinking, and is frequently characterized by denial of its existence," the court said it is important to distinguish conduct-which is a critical factor in a doctor's ability to practice-from illness. Id.

An argument could be made that permitting doctors suffering from mental illness to practice "undermines public confidence in the integrity of the profession." However, this speculation is insufficient to preserve illness-based restrictions for two reasons. First, the theory is based on myths and prejudices against the mentally ill. Second, although a greater number of the mentally ill may be impaired, so that restrictions based on sickness might be rationally related to the legitimate state interest of protecting the public, that is no longer enough. Because restrictions are based on disability, the ADA requires they survive strict scrutiny. They cannot. See infra text accompanying notes 75-76.

On the other hand, in some jurisdictions, drug use may constitute grounds for discipline even absent impairment. This argument rests on the notion that the doctor "occupies a unique and centralized position in the overall elaborate regulatory scheme established by the Legislature to control dangerous drugs and narcotics." B.W. v. Board of Medical Quality Assurance, 215 Cal. Rptr. 130, 135 (Cal. App. 1985). See also Furer v. Sobol, 576 N.Y.S.2d 632, 633 (1991) holding there is "no necessity" of impairment due to drugs for boards to impose probation. Board sanctions would survive if applied only to current drug users-a group explicitly excluded from ADA protection-because they meet the weak level rational basis test. However, attempts to sanction former, or those merely regarded as, substance abusers would probably fail because they cannot satisfy strict scrutiny. See infra notes 75-86 and accompanying text.) However, because the physician's license represents a constitutionally protected interest, (Although the right to practice medicine is a property right, it is "conditional and subject to the police power of the state." Garrison v. Board of Trustees of Memorial Hospital of Laramie County, Wyoming, 795 P.2d 190, 193 (Wyo. 1990). By establishing criteria for discipline, states create "a 'property' interest in a blemish-free license to practice medicine." Fleury v. Clayton, 847 F.2d 1229, 1232 (7th Cir. 1988). While the Supreme Court has consistently held that injury to reputation is not by itself a protected liberty interest (e.g., Siegert v. Gilley, 500 U.S. 226, 233 (1991)), by imposing and reporting license restrictions, boards do more than affect a doctor's reputation. They also influence his ability to work.) it cannot be revoked, suspended or restricted without due process. (Procedural due process is generally satisfied by timely and complete explanation of the charges and a hearing, the parameters of which vary from state to state. Reaves, supra note 20, at 123-28.

Determination of constitutionally required due process for a particular situation is essentially a balancing test involving consideration of gov-ernmental interests in efficiency and accurate determinations, private concerns at stake in the case, the complexity of the issues, the nature of the proceedings and its other safeguards, and an assessment of the danger to society from inaccurate determinations in each direction. Sherman v. Comm'n on Licensure to Practice, 407 A.2d 595, 600-01 (D.C. App. 1979).

See also Devous v. Wyoming State Bd. of Medical Examiners, 845 P.2d 408, 415 (Wyo. 1993) (citing Gilchrist v. Bierring, 14 N.W.2d 724, 732 (Iowa 1944)).

The right to earn a living is among the greatest of human rights and, when lawfully pursued, cannot be denied. It is the common right of every citizen to engage in any honest employment he may choose, subject only to such reasonable regulations as are necessary for the public good. Due process of law is satisfied only by such safeguards as will adequately protect these fundamental, constitutional rights of the citizen. Where the state confers a license to engage in a pro-fession, trade, or occupation, not inherently inimical to the public welfare, such license becomes a valuable personal right which can-not be denied or abridged in any manner except after due notice and a fair and impartial hearing before an unbiased tribunal. Were this not so, no one would be safe from oppression wherever power may be lodged, one might be easily deprived of important rights with no opportunity to defend against wrongful accusations. This would subvert the most precious rights of the citizen.)

A recent increase in physician disciplinary actions (The number of physicians disciplined in 1994 increased by 11.8 percent over 1993. The 3685 doctors sanctioned in 1994 is 40 percent greater than three years ago. This number represents 0.6 percent of the 615,854 licensed physicians in the United States. Punishing of Doctors Increased in 1994, THE NEW YORK TIMES, April 6, 1995, at A20 col. 4.

The rates of disciplinary actions vary. An interesting, but unexplained, problem is "an inverse relationship ... between rates of licensure actions and the size of the state's physician population, i.e., the greater the number of physicians in a state, the lower the state's licensure action rate and vice versa." Mullan, supra note 15, at 75.) follows years of criticism that boards too often protect incompetent doctors. (The authors of one interesting empirical study conclude the recent increase in use and severity of physician discipline has had little impact on incidents of malpractice. See generally Lawrence Southwick, Jr. & Gary J. Young, Doctors, Lawyers, and Malpractice Insurance: Is Physician Discipline or Legal Restriction the Answer?, 12 LAW & POL'Y 155 (Apr. 1990). "[S]erious disciplinary actions" against doctors rose from 1437 in 1990 to 2013 in 1991. Too Few Actions Reach Incompetence, Negligence, Public Citizen Study Claims, 2 HLR 3 d23 (Jan. 21, 1993). However, the increase might be attributable to a new Federation classification system rather than a change in policy, according to a non-profit consumer advocacy group study. The Public Citizen Report explained that "license restrictions distinct from probation" are now included. Id.) Boards are supposed to punish (Sanctions range from an informal confrontation resulting in an agreement to participate in a rehabilitation program without license restriction to suspension or revocation following a formal hearing. Robert S. Walzer, Impaired Physicians An Overview and Update of the Legal Issues, 11 J. LEGAL MED. 131, 134 (1990). Dr. Walzer provides a review of a representative sample of medical board procedures.

Revocation is a particularly harsh remedy. Not only does the physician lose his license to practice, but "any property rights or interest stemming from that license are likewise voided or annulled." Pittenger v. Department of State, Bureau of Professional and Occupational Affairs, 596 A.2d 1227, 1230 (Pa. Cmwlth. 1991) (quoting Keeley v. State Real Estate Comm'n, 501 A.2d 1155, 1158 (Pa. 1985)). Courts recognize the "gravity of the situation .... [w]ithout his license he will lose his practice, and without his

practice, he will lose his livelihood." Wills v. Board of Medical Examiners, 384 S.E.2d 636, 638 (Ga. 1989).

At the opposite end of the spectrum, under certain circumstances, boards consider dispositions which are not disciplinary action and thus need not be reported. These letters of agreement may be appropriate if the physician is recovering from substance abuse, patient health has not been threatened, and the doctor identified himself to the board prior to any outside reports. These agreements require the doctor waive confidentiality for current and future employers and other state boards where he either disputes the misconduct allegation or is licensed. James S. Bolan, Practice before the Board of Registration in Medicine, 38 BOSTON B.J. 5 (May/June 1994). Boards also possess authority, "by adjudication and order to limit or otherwise restrict a license or to require the physician to submit to care, counseling, or treatment" by a board doctor. Robert L. Sadoff and Julie B. Sadoff, The Impaired Health Professional Legal and Ethical Issues, in PSYCHIATRIC-LEGAL DECISION MAKING BY THE MENTAL HEALTH PRACTITIONER THE CLINICIAN DE FACTO MAGISTRATE 259 (Harvey Bluestone et al., eds. 1994) [hereinafter The Impaired Health Professional].

A board imposed penalty will only be modified if it was not supported by the findings. '"The propriety of a penalty imposed by an administrative agency is a matter vested in the discretion of the agency, and its decision may not be disturbed unless there has been a manifest abuse of discretion.'" Williamson v. Board of Medical Quality Assurance, 266 Cal. Rptr. 520, 522 (Cal. App. 1990) (quoting Lake v. Civil Service Comm'n, 47 Cal. App. 3d 224, 228 (1975)).

Commentators suggest licensing boards have historically failed as a deterrent to "deficient but not completely incompetent" physicians. Jost, supra note 5, at 586. Professor Jost argues traditional revocation and suspension remedies are so harsh they

are "seldom used." Other sanctions, including "continuing supervision, forced contin- uing education, or re-examination, are more responsive" to most problems boards face. Professor Jost also proposes restitution for victims. Id.) and deter bad doctors. Doctors should be disciplined for improper behavior, not because they are sick. (Attempts to raise illness as an issue to mitigate sanctions achieve varying degrees of success.) Because past professional incompetence or misconduct is a proper factor in a board's decision on appropriate sanction, (Boards enjoy "considerable discretion ... 'to effectively address the varied degrees of culpability that are often associated with acts of professional misconduct and to tailor an appropriate sanction to the particular facts and circumstances of the case.'" Colorado State Bd. of Medicine v. Hoffner, 832 P.2d 1062, 1068 (Colo. App. 1992) (quoting Kibler v. State, 718 P.2d 531, 535 (Colo. 1986)).) information about these restrictions is relevant. Disclosure of restrictions based on sickness is not. (In some jurisdictions, impaired physicians can avoid investigation or discipline by entering an approved diversion program. See, e.g., CAL. BUS. & PROF. CODE ~ 2340 (Deering 1995). However, to be eligible for this protection, the physician may need to be a formal participant in the program. Kees v. Board of Medical Quality Assurance, 10 Cal. Rptr. 2d 112, 117-18 (Cal. App. 1992).

In Florida, a consultant determines when in his "professional judgment intervention is necessary" based on evidence of impairment. FLA. ADMIN. CODE ~ 61-10.007(5) (1995). The impaired physician participates voluntarily, but if he leaves prior to successful completion of the program, "all information concerning the practitioner's case will be forwarded to the Department." Id. at ~ 61-10.007(6)(c). Unfortunately, this is not the only way the information may become public. H.J.M. v. B.R.C. & R.H.C., 603 So.2d 1331 (Fla. Dist. Ct. App. 1992).

In H.J.M., the court permitted medical malpractice plaintiffs to discover information about defendant physician's treatment received at a substance abuse facility while he was in the impaired practitioner's program. The doctor had mentioned his treatment during a deposition, but refused to comply with a request for all his records. Nevertheless, after an in camera review, the trial court required disclosure. The order concluded "the need for and probative value of the information outweighed the possible harm of disclosure to Dr. M., and that the subject material would be disclosed only to the parties, counsel of record, and persons employed by them in preparing for trial. The court expressly recited that it had not determined whether the material would ultimately be admissible at trial." Id. at 1332.

Dr. M. also refused to comply with subsequent attempts to depose him concerning his past substance abuse and information relating to treatment at two rehabilitation facilities. The appellate court also affirmed the trial court in requiring this testimony. Further, the doctor waived the psychotherapist-patient privilege by providing part of the information prior to raising this argument. Id. at 1334)

D. Previously Licensed Physicians

When a physician applies for a license in a different state, queries to data banks or to other boards may reveal restrictions or adverse actions. Professional regulation is a state function; therefore, if boards discover a physician's license is restricted in another jurisdiction, (As early as 1938, the Michigan Supreme Court concluded granting or denying a license to a physician from another state is within the board's discretion. "In exercising supervision over the health of several millions broad discretionary powers must be necessarily granted, and it is only when that discretion is abused that the courts will interfere." Salowitz v. Michigan State Bd. of Registration in Medicine, 280 N.W. 737, 740 (Mich. 1938).) they have options-some appropriate, some not. (Boards do misuse information obtained from other states. One example, although not based on illness, is Mannan v. District of Columbia Bd. of Medicine, 558 A.2d 329 (D.C. Cir. 1989). Doctor Mannan, who was licensed in the District of Columbia, Maryland, and Michigan, was charged with Medicaid fraud in Maryland. On advice of counsel, he agreed to a plea "prior to judgment" and probation. Id. at 330-31. His Maryland license was not restricted, and he was allowed to continue practicing. Id. at 331.

As part of the license renewal process in the District of Columbia, he informed the board of his status in Maryland. Id. The D.C. board filed a notice of intent to revoke his license for professional misconduct based on his "conviction" in Maryland and "for willfully making and filing false reports" in Maryland. 558 A.2d at 331-32. Without understanding the plea proceeding, the D.C. board inexplicably chose to ignore evidence that the Maryland board viewed the plea and proceeding "completely differently." Id. at

339. Particularly important for the issue in this article, the court concluded the evidence should have been considered because the Maryland Commission "presumably has a better understanding" of their own state law. Id.

The same is true for illness-based restrictions imposed by one state. The state which discovered the problem can investigate and decide on appropriate action. A state can certainly reach a different conclusion on what constitutes proper resolution. However, if it uses another state's action as the basis for its decision, the board should understand and consider the original state's concerns and determination. If, on the other hand, the board does not wish to consider the first state's resolution, it should simply initiate a de novo review) Boards can simply ignore the information and conduct their own investigation. They can also treat the report as one factor in their decision-making process. A problem occurs, however, when boards treat an illness-based restriction as grounds for denying a license. Boards do have the right-indeed the obligation-to make licensing decisions based on the competence of the applicant. (See, e.g., Department of Professional Regulation v. Durrani, 455 So. 2d 515 (Fla. Dist. Ct. App. 1984). The court acknowledged that a statutory provision "clearly empowers" the medical board to promulgate rules to implement licensure by endorsement. Agency interpretive rulemaking is entitled to deference. Id. at 517. "The challenged rule, consistent with the legislative intent of uniformity, adopts the same passing score for endorsement" as for examination candidates. Id. at 518. The court concluded additional criteria-minimum score and requirement all scores be obtained at one sitting-"are reasonably related to the statutory purpose of requiring some basic level of medical competence to assure protection of the public health, safety and welfare." Id.) Information about the physician's level of care in another state is certainly relevant to whether he is likely to practice with skill and safety if granted a license in this state. (One Florida physician optimistically asserts "[e]ach state will usually look into the reason a physician was disciplined in another state and act appropriately." Richard J. Feinstein, Special Report the Ethics of Professional Regulation, 312 NEW ENG. J. MED. 801, 804 (Mar. 1985). He also explains boards ask about disciplinary actions in other jurisdictions as part of the process of licensing doctors based on examinations. An admission of disciplinary action in another state is always investigated before a license is granted." Id.) On the other hand, using an illness-based restriction to deny a license is inappropriate and violates the ADA.

II. NATIONAL DATA BANKS

A. Federation of State Medical Boards

Sensitive to a growing national concern about bad doctors, and committed to eliminating "individuals Senator Heinz has so appropriately called 'unethical, unfit, carpetbagging doctors,'" the Federation increased its efforts and computerized its disciplinary data bank. (Galusha Statement, supra note 14, at 54-55. The average time for disciplinary searches is 65 seconds.) All disciplinary actions resulting from formal charges are "reviewed, categorized and distributed monthly" to Federation members and Canadian provinces' licensing authorities. (Id.) All member boards contribute to the data bank.

Illness-based actions which do not lead to license revocation, suspension, or probation are probably

reported under an ambiguous "health-related problems" code. (FSMB Disciplinary Coding, Miscellaneous ~415.3.) But, if a doctor's license is revoked, suspended, or he is placed on probation because of illness, the only applicable code provision seems to be "mental reasons." (Id. at ~~ 120, 220, 320) While it is certainly troubling to require reports of any "health related problems," limiting information to only "mental reasons"-whatever that is-is even more problematic.

In the mid 1980's, even with the Federation's national reporting system-which physicians argued was greatly improved and still growing-Congress feared incompetent doctors were continuing to practice by moving to other states.

B. National Practitioner Data Bank

The 1986 Health Care Quality Improvement Act was a Congressional attempt to resolve the problem (GUIDEBOOK, supra note 22, at 1. Congress intended to overcome reluctance to engage in meaningful peer review by granting immunity to persons who participate in a professional review action "in the reasonable belief that the action was in furtherance of quality health care." 42 U.S.C. ~ 11112(a)(1) (1995). This part of the Act is beyond the scope of this article. The Act also requires "a reasonable effort to obtain the facts...." Id. ~ 11112(a)(2). Professional review action based on disability-without investigation of the conduct requiring the action-could invalidate the statutory immunity shield and subject reviewers to liability. Id. ~ 11111(a)(1).) and "improve the quality of medical care." (While the goal is important, new data about incidence of mental illness and its effect on sufferers cast serious doubt on restrictions on clinical privileges imposed solely because of disability. See infra notes 87-88 and accompanying text.) Based on "a national need" to prevent bad doctors from moving "from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance," (42 U.S.C. at 11101(2) (1995).) Congress authorized creation of a national, comprehensive (Medical boards must report license revocations, suspensions, restrictions, as well as censures, reprimands, probation and license surrenders. 42 U.S.C. ~ 11132(a)(1)(A), (B) (1995).

Health care entities must report "professional review action that adversely affects" a doctor's clinical privileges. Id. ~ 11133(a)(1)(A). These entities must also report a physician's surrender of his clinical privileges if related to, or to avoid, an investigation into "possible incompetence or improper conduct." Id. ~ 11133(a)(1)(B)(i).

Professional societies must report "review action which adversely affects the membership of a physician in the society." Id. ~ 11133(a)(1)(C). "'Adversely affecting'" is defined to include "reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." 42 U.S.C. at ~ 11151(1).

The Act requires reporting by any entity which makes a payment settling or partially settling, or satisfying a judgment in a malpractice claim. For purposes of this reporting requirement, "entity" does not include an individual doctor. Although the Act does not explicitly define the word, the Circuit Court of Appeals for the District of Columbia concluded Congressional intent was to limit entities to groups

and organizations and to exclude individual practitioners. American Dental Ass'n v. Shalala, 3 F.3d 445, 446-48 (D.C. Cir. 1993).

Legislators recognize that malpractice claims may be paid for many reasons unrelated to validity of the demand. Consequently, the Act provides settlement "shall not be construed as creating a presumption that medical malpractice has occurred." 42 U.S.C. ~ 11137(d). However, drafters must have thought some inference was appropriate otherwise there would be no reason to mandate reporting the information.

Nevertheless, jury instructions that reporting requirements are "'absolutely irrelevant'" to whether malpractice was committed were recently upheld. Sedlitsky v. Pareso, 625 A.2d 71, 73 (Pa. Super. 1993) (quoting Levine v. Rosen, 616 A.2d 623, 627 (Pa. 1992)). The doctor argued that, because of mandatory reporting under the HCQIA, this instruction "'falsely trivializes the importance of the case to the defendant physician.'" Id. (quoting Appellant's Brief at 10). The court conceded this federal legislation might increase the malpractice judgment's negative impact on a doctor's reputation but rejected his argument.) reporting system. (42 U.S.C. ~ 11134(b) (1995). The Secretary of Health and Human Services supervises the system.) After several delays, the National Practitioner Data Bank finally opened in 1990. (Elisabeth Ryzen, The National Practitioner Data Bank Problems and Proposed Reforms, 13 J. LEGAL MED. 409 (1992).

A 1993 General Accounting Office report identified several continuing problems with the NPDB. See generally GENERAL ACCOUNTING OFFICE, REPORT TO THE SECRETARY OF HHS, HEALTH INFORMATION SYSTEMS (1993). These problems include that: 1) HHS management permits weaknesses which jeopardize "timely, secure, and cost-efficient operation," 2) responses take several weeks which delays the granting of privileges, 3) inadequate internal controls allowed "sensitive practitioner data" to be sent to organizations not entitled to the information, 4) HHS failure to properly monitor the data bank contractor permitted automated system problems to continue, and 5) HHS plans to redesign the data bank "have not incorporated a sound system development approach and are based on funding uncertainties." Id. at 2-3. Most troublesome for the issue in this article, of course, is the inappropriate release of sensitive physician information to unauthorized entities.

The Data Bank received 3,462,297 queries and 82,623 reports of malpractice payments or adverse actions by April, 1994. U.S. DEP'T. HEALTH AND HUMAN SERVICES, NATIONAL PRACTITIONER DATA BANK PROFILE OF MATCHES UPDATE, OEI-01-94-00031 (1994). When there is a query about a practitioner against whom a report has been filed it is called a "match." By April, 1994, there were 152,941 matches. In fact, by February, 1994, there were almost seven times as many matches as there had been two years earlier. Id. Approximately half of the matches of adverse action reports were filed by state licensing boards. Further, the percentage of interstate matches increased from 9.3 to 15.3. Id. at 2. See also Use of National Practitioner Data Bank, Number of Matches Growing, HHS Inspector General Says, 5 MCR 33 d8 (BNA Medicare Report Aug. 19, 1994).)

The Act requires medical boards report any action which "revokes or suspends (or otherwise restricts) a

physician's license." (42 U.S.C. ~ 11132(a)(1)(A) (1995).

"Reportable actions must be based on reasons relating to professional competence or professional conduct which affects or could adversely affect the health or welfare of a patient. Matters not related to the professional competence or professional conduct of a [practitioner] are not to be reported to the Data Bank." GUIDEBOOK, supra note 22, at 17.

In fact, during the notice and comment period, a majority of the comments on reporting licensure actions criticized disclosing actions unrelated to professional conduct or competence. Id. at app. C (citing 45 C.F. R. Part 60). Acknowledging the purpose of the Data Bank is to prevent incompetent physicians from moving to a new location where their past bad practices are not known, the response was "the Secretary intends to collect only data relating to professional competence or misconduct." Id., (citing 54 Fed. Reg. 42,722, 42,726 (1989)).) Combined with severe penalties for failing to comply with mandatory reporting, (The Secretary will replace boards which fail to comply with another qualified entity for reporting. 42 U.S.C. ~ 11132(b) (1988). Health care entities which do not report face loss of the statutory immunity protection. Id. at ~ 11133(c)(1).) this ambiguous "otherwise restricts" language may cause boards to err (Adverse action reports must be submitted on forms supplied by the National Practitioner Data Bank. Entities must choose a classification code. Although an entity may explain the action, it can only use up to 600 characters, including punctuation and spaces. GUIDEBOOK, supra note 22, at app. D.

A board which restricts a license without revoking, suspending, or imposing probation on the physician must report under the five digit code classification for "Other Miscellaneous Action (Including Censure and Surrender)." ADVERSE ACTION CLASSIFICATION CODES, NPDB FORM. The form also permits the board to provide a "brief description of the acts or omissions, or other reasons for the adverse action taken." Id. at ~ C.31. In licensure actions, a portion of the extremely limited space must be used to describe the state medical board. Combining an ambiguous classification code with an insufficient opportunity to explain magnifies the potential for misunderstanding and bad results.) on the side of reporting. (Based on the "lack of uniformity" in state laws which regulate doctors, one physician noted the "remarkable variability in the reporting of adverse actions involving practitioners' licensure ... should be expected." Bernard S. Goffen, Letters, the National Practitioner Data Bank: Bane or Benefit?, 268 JAMA 3429 (1992). Because sources demonstrated a "glaring absence of conformity," Doctor Goffen proposed creating "national standards for validity, comparability, and acceptability." Otherwise, Dr. Goffen feared, the NPDB might experience consequences of "'garbage in, garbage out.'" Id.

Doctors and other professionals concurred in Dr. Goffen's concerns but disagreed with his conclusion. They argued the differences were a function of "the variability in practice relating to disciplinary actions and reporting" rather than quality of physicians in a particular location. Fitzhugh Mullan et al., In Reply, 268 JAMA 3430 (1992). These physicians suggest that, because boards retain the task of assessing information received, they should develop "rigorous and uniform [national] standards."

Another physician objected to the "methods used and extreme potential for abuse," based on absence of

information "as to what is admissible or pertinent." Michael Dube, Letters, 268 JAMA 3429 (1992). The reply referred to the one hundred page NPDB guidebook and supplement. In Reply, at 3430

Commentators have also objected that classification codes and limitations on descriptions may "lead to inaccuracies in reporting." Ilene D. Johnson, Reports to the National Practitioner Data Bank, 265 JAMA 407, 410 (1991).) Nevertheless, when boards report any restriction, including those based only on illness, (Prior to the HCQIA, actions based on professional impairment represented only a small percentage of sanctions reported. Walzer, supra note 35, at 135. The explanation is, according to Dr. Walzer, once identified, most impaired physicians succumbed to a board's "coercive effort to intervene." Id. Intervention refers to "advocacy-oriented confrontation of an impaired physician, often by trained physician intervenors, upon probable cause based on information from reliable reports." Id. at 138. So long as the physician submitted to the intervention, information remained confidential. As a result, "[o] nly uncooperative impaired physicians" were formally disciplined and reported. Id. at 135. Nevertheless, although more than forty states explicitly authorize boards or medical societies to investigate and rehabilitate rather than sanction impaired physicians, the extent of confidentiality varies. Walzer, supra note 35 at 139-68.) they are submitting non-reportable information and incorrectly implying that sickness necessarily suggests incompetence. This not only exceeds HCQIA requirements, and improperly infringes upon the doctor's right to privacy, it violates the ADA.

C. Right to Privacy

Courts have little difficulty rebuffing right to privacy objections to disclosure of a doctor's medical history. Because the right to privacy is not absolute, courts balance the physician's right against the state's interest. (E.g., Humenansky, 525 N.W.2d at 567.) A California court acknowledged the privacy right "encompasses mental privacy, including thought, emotions, expressions, and personality." (Kees v. Board of Medical Quality Assurance, 10 Cal. Rptr. 2d 112, 119 (Cal. App. 1992).) Nevertheless, the court upheld a statute permitting the board to order physicians whose ability to practice is impaired due to mental illness to submit to psychiatric examinations. The court balanced the individual's privacy interest against the state's "compelling need to protect the public against risk of harm by physicians who are so impaired they cannot practice medicine safely." (Id.) The statute survived constitutional challenge because the court interpreted the provision to only allow psychiatric examinations "if such an examination is the least intrusive means of determining a physician's mental condition." (Id.)

The South Carolina Supreme Court reached a similar conclusion. (State Bd. of Medical Examiners v. Fenwick Hall, 419 S.E.2d 222 (S.C. 1992).) Despite a federal statute providing confidentiality for substance abuse program participants, the court granted a board petition for disclosure of a doctor's medical records. The court conceded "potential harm to the physician, the physician-patient relationship, and the treatment services." (Id. at 224.) Nevertheless, the court agreed with the board's argument "that it is virtually impossible to conceive of a situation which would pose a greater threat to life or serious bodily harm than a physician practicing under the influence of drugs." (Id.) Under those circumstances, the need for disclosure as part of a confidential board investigation outweighs the potential harm. (Id.) The balance should shift, however, when reporting illness-based restrictions. Sick doctors who are not impaired, pose no additional risk to the public.

Additionally, the South Carolina court was clearly influenced by the safeguards against unnecessary disclosure of confidential information. ("The Board in conducting its investigation would retain the confidentiality of the records." 419 S.E.2d at 224.) The NPDB collects and disseminates private information. Although access to this sensitive material is supposed to be limited, inadequate safeguards and inappropriate disclosure of confidential information are recurring criticisms of the Data Bank. (See supra note 52.)

When boards move from appropriate inquiry about impairment to improper questions about illness, courts must reweigh individual versus state interests. The threat to confidentiality posed by national data banks increases the potential infringement of the doctor's right to privacy. But, even if courts continue to reject privacy claims, illness-based restrictions cannot survive challenges under the ADA.

III. AMERICANS WITH DISABILITIES ACT

The ADA was passed to protect 43 million (More recent estimates are that 49 million Americans are disabled. JOHN M. MCNEIL, AMERICANS WITH DISABILITIES: 1991-92, DATA FROM THE SURVEY OF INCOME AND PROGRAM PARTICIPATION 5 (U.S. Bureau of the Census, Current Population Reports, Pub. No. P70-33 1993) cited in Peter David Blanck, Employment Integration, Economic Opportunity, and the Americans with Disabilities Act: Empirical Study from 1990-93, 79 IOWA L. REV. 853, 854-55 (1994).) Americans with disabilities (The ADA provides protection for qualified individuals with a disability. Disability includes not only "a physical or mental impairment that substantially limits one or more of the major life activities" but also "a record of such impairment" or "being regarded as having such impairment." 42 U.S.C. ~ 12102(2) (1995). This means the Act covers physicians who suffer from or have a history of mental illness. But, the ADA also protects those who are merely "regarded as" disabled. By using illness as a criterion for restricting licenses, boards regard these doctors as disabled.

Substance abusers are a particular problem. In fact, "violations involving drugs or alcohol seem to account for three-fourths or more of all disciplinary actions." Havighurst, supra note 12, at 401. The ADA specifically does not protect current drug users because a current user is not a qualified individual. 42 U.S.C. ~ 12114 (1995). Although not explicit, the Act appears to treat current alcohol abusers similarly. However, people who are no longer substance abusers, or those who were merely "regarded as" using drugs, are protected. 42 U.S.C. ~ 12114(b).) from discrimination resulting from "society's accumulated myths and fears about disability." (Schoolboard of Nassau County v. Arline, 480 U.S. 273, 284 (1987).) Recognizing that people with disabilities "continually encounter various forms of discrimination ... and relegation to lesser ... jobs, or other opportunities," (42 U.S.C. ~ 12101(5) (1995).) Congress attempted to eliminate this discrimination. ("The ADA establishes a clear, comprehensive prohibition of discrimination on the basis of one's disability and provides a national mandate with strong enforceable standards to bring the disabled into the mainstream of American life." Rivera Flores v. Puerto Rico Tel. Co., 776 F. Supp. 61, 69 (D.P.R. 1991).) Limiting a physician's license merely because he is sick-rather than determining if he is impaired and thus needs restrictions to be able to practice with

skill and safety (Using studies conducted over several decades, one commentator argues many illegal drug users "function effectively at work and in other areas of social life." Charles Winick, Social Behavior, Public Policy, and Nonharmful Drug Use, 69 MILBANK Q. 437 (1991). Dr. Winick conceded that drug dependent physicians are "especially troubling." Nevertheless, he claimed, "[t]here are no reports demonstrating that addicted physicians are more likely to commit malpractice than others." Id. at 441. In fact, according to the country's largest program for addicted health care providers, a doctor's professional activities are "the last aspect of his or her life to be affected by drug dependence." Id. (citing G.D. Talbott and C. Wright, Chemical Dependency in Health Care Professionals, 2 OCCUPATIONAL MED. ST. OF THE ART REVIEW 581 (1987)). Contrary to the common perception, Dr. Winick concluded drug addicted doctors "typically have successful and active primary care practices." Id.) -represents impermissible discrimination. In fact, recent medical research demonstrates a board might grant a license it "otherwise restricts" to sick people who may never be impaired or pose increased risk to patients. (Boards generally do not have to establish that a doctor's practice represents an "actual threat of harm" to his patients or the public to revoke his license. In re Guess, 393 S.E.2d 833, 836 (N.C. 1990). Instead, "a general risk of endangering the public is inherent in any practices which fail to conform to the standards of 'acceptable and prevailing' medical practices." Id. at 837. This is because preventing deviation from the standard, regardless of potential injury, is rationally related to protecting the public from "'the consequences of ignorance and incapacity as well as of deception and fraud.'" Id., (quoting Dent, 129 U.S. at 122).

Absent a fundamental right or suspect class, this is the appropriate test for most license restrictions. However, the level of scrutiny is different when the limitation is based on disability. Under the ADA, boards must establish licensees represent a "direct threat" before restriction based on disability is appropriate. Mary Anne Bobinski, Autonomy and Privacy: Protecting Patients From Their Physicians, 55 U. PITT. L. REV. 291, 320 (1994).) By confusing illness with impairment, boards act contrary to the purpose of the ADA and improperly relegate these individuals to "lesser ... opportunities."

Further, the ADA raises people with disabilities to suspect class status. (42 U.S.C. ~ 12101(7) (1995).) Therefore, to continue to impose and report illness-based restrictions, boards must demonstrate these actions pass the strict scrutiny test. Although boards can show a compelling state interest in protecting the public from incompetent physicians, imposing and reporting illness-based restrictions is not narrowly tailored to effectuate that interest. As a result-these restrictions and the reports-violate the ADA. (Other challenges to these restrictions have failed. Limitations on who may query the Data Bank-state licensing boards, hospitals, and other health care entities-are probably sufficient to overcome a physician's constitutional challenges to this invasion of privacy. See Bobinski, supra note 74, at 333-39, for a discussion of constitutional challenges to disclosure of private physician information.

Although courts recognize a physician's interest in his reputation, these claims have also been unsuccessful. Nevertheless, it is important to recognize that "Data Bank reporting requirements have a direct effect on the professional life of a physician, particularly since there is no provision for the removal of information once provided." Nolan N. Atkinson Jr., How the National Practitioner Data Bank Affects Medical Malpractice Clients, 5:1 THE PRACTICAL LITIGATOR 35-38 (1994).

The Act provides some protections to insure the information in the Data Bank is correct. For example, the physician may request disclosure of reported information. Further, the Act requires the Secretary establish procedures for disputing the accuracy of the information. 42 U.S.C. ~ 11136(1), (2) (1995).)

A. Protection Under the ADA

Title II (The Act is divided into several parts. The provisions relevant to this article are found in the preliminary statement of the purpose to establish a national commitment to eliminate discrimination, Title I which prohibits discrimination in employment and Title II which extends protection to benefits provided by a public entity. A discussion of Title III on public accommodations, Title IV on telecommunications, and miscellaneous provisions in Title V is beyond the scope of this article.) regulations prohibit public entities from administering "a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination based on disability ...." (28 C.F.R. ~ 35.130(b)(6) (1994).) Public entities include "any ... instrumentality of a state." (42 U.S.C. ~ 12131(1)(b) (1995).) Medical boards, acting as agents of the state, (See supra text accompanying note 19. Indeed, the NATIONAL PRACTITIONER DATA BANK GUIDEBOOK defines Board of Medical Examiners as "a body or subdivision of such body which is designated by a State for the purpose of licensing, monitoring and disciplining physicians ... includes ... a composite board, a subdivision, or an equivalent body as determined by the State." GUIDEBOOK, supra note 22, at 47.) are public entities. Impermissible discrimination includes "limiting, segregating, or classifying" a disabled person based on his disability. (42 U.S.C. ~ 12112(b)(1) (1995).)

When boards withhold licenses or impose restrictions-such as monitoring or mandatory continued participation in a substance abuse program-based solely on sickness or past drug or alcohol abuse, they violate the ADA by "limiting" the licensee and adversely affecting his status or opportunity because they regard him as disabled. Indeed, public entities should not even ask about illnesses. (See generally Coleman and Shellow, supra note 4.) Instead, their only legitimate concern is whether "with or without reasonable modifications" the licensee meets "essential eligibility requirements for ... participation in programs or activities" provided by the board. (42 U.S.C. ~ 12131(2) (1995).)

Moreover, the Act places the burden of proof on boards. They must prove essential licensure requirements and justify the need for specific discriminatory methods. Although a board's decision on what constitutes "essential eligibility requirements" is "entitled to some deference in view of its experience and knowledge," (Medical Society of N.J. v. Jacobs, No. 93-36-70, 1993 U.S. Dist. LEXIS 14294, at *16-17 (D.N.J. Oct. 5, 1993), modified, Medical Society of N.J. v. Jacobs, 1994 U.S. Dist. LEXIS 15261 (D.N.J. Sept. 23, 1994).) the criteria cannot impose additional, unnecessary burdens on qualified individuals with disabilities.

Using disease as a criterion violates this rule. (This does not mean, of course, that mental illness or substance abuse protects a doctor from board action. Boards may restrict or revoke a license if the physician's illness manifests in conduct which might injure a patient, even if no patient has been harmed. The restriction would be appropriate and permissible under the ADA so long as it was based on the

doctor's conduct-whatever its cause-rather than illness. For example, a physician's public intoxication, fight and violent acts in resisting arrest in a "state of undress on the street"-in addition to her previous substance abuse problems-were proper considerations in deciding whether to re-impose probation. Major v. Department of Professional Regulation, 531 So. 2d 411, 412 (Fla. Dist. Ct. App. 1988). "Based on proof of such conduct," the board decided Dr. Major was unable to practice with skill and safety. Id. at 413 (emphasis added). The board concluded the "fact that no patient harm occurred was fortuitous." Id.) Boards use disability to impose the additional burden of a restricted license requiring monitoring or participation in an impaired physician's program. Because there simply is no proof that history of mental illness or substance abuse prevents licensees from possessing essential requirements to practice with skill and safety, (A non-physician consultant to the West Virginia impaired physician program objected to a board press release identifying three doctors whose licenses were restricted based on substance abuse. H. Wayne Dickison, Peer Assistance, Not Public Identification, 85 W. VA. MED. J. 390 (1989). "To single out a physician who has voluntarily sought help for a treatable illness because that illness involves drug or alcohol misuse is discriminatory to say the least. There is ample evidence to show that such physicians present no greater risk to patient care than a physician treated for any other chronic medical problem." Id.) these additional burdens are unnecessary.

In fact, most mental illnesses never cause functional impairment. According to a National Institute of Mental Health study, while about 28 percent (This number includes substance abusers. See generally D. A. Regier et al., The NIMH Epidemiologic Catchment Area Program, 41 ARCHIVES OF GEN. PSYCHIATRY 934 (1984).) of the population suffer from mental illness, approximately two-thirds of these sick people are not impaired by their psychiatric condition. (The numbers should be approximately the same for doctors as for the rest of the population. In a recent study, the authors concluded doctors were as likely as others in their age and peer groups to experiment with illegal drugs during their lifetimes. Patrick H. Hughes et al., Prevalence of Substance Use Among US Physicians, 267 JAMA 2333 (1992). Although physicians were less likely to currently be using illicit substances, they reported a higher incidence of alcohol abuse than the general population. The researchers suggested increased use of alcohol was likely attributable to socio-economic status, rather than profession. Physicians were also more likely to use some types of prescription drugs, presumably because of a high rate of self treatment with controlled medications. Estimates of number of doctors sanctioned by state licensing boards and treated in impaired physician programs vary between one and three percent. Alcoholism is "slightly more prevalent" than drug abuse. Id. at 2338. But this does not mean, according to the authors, that doctors treat patients when they are intoxicated or drug impaired. Id. at 2333-38.

Nevertheless, while the number may be small, some physicians engage in high risk behavior. "The challenge is to identify these physicians early and help them avoid the adverse effects of substance abuse and dependence." Id. at 2338. The authors suggest a shift in focus to concern for the doctor and away from punishment and judgment provides one reason for high success rates reported by some state medical society treatment programs. Id. at 2338-39.) Thus, illness-based restrictions are unnecessary except to further prejudice against people with disabilities that the ADA was passed to eliminate. Fortunately, courts are beginning to agree and recognize impairment, rather than illness, is the issue. (Jacobs, 1993 U.S. Dist. LEXIS, at *20. "The essential problem with the present questions is that they substitute an impermissible inquiry into the status of disabled applicants for the proper, indeed

necessary, inquiry into the applicant's behavior." Id.)

B. Providing Title I Protections

Title II explicitly prohibits discrimination but provides only broad outlines rather than specifics. By contrast, Title I-which prevents discrimination in employment-is much more detailed.

Although medical boards are not technically employers, they should be required to comply with Title I protections for several reasons. First, the ADA was designed to expand protection for persons with disabilities. Consequently, consistent with legislative intent, any ambiguity should be resolved in favor of greater-rather than lesser-protection. (See, e.g., Robert W. Edwards, Note, The Rights of Students with Learning Disabilities and the Responsibilities of Institutions of Higher Education under the Americans with Disabilities Act, 2 J.L. & POL'Y 213, 215 (1994); Sidney D. Watson, Eliminating Fear Through Comparative Risk: Docs, Aids, and the Anti-Discrimination Ideal, 40 BUFF. L. REV. 739, 768 (1982).) Second, board action affects a physician's employment situation. For example, license restrictions influence clinical and hospital staff privileges. (Physicians must have access to hospitals. Doctors need staff privileges to admit patients and use hospital resources. Josephine M. Hammack, Note, The Antitrust Laws and Medical Peer Review Process, 9 J. CONTEMP. HEALTH L. POL'Y 419 (1993). The HCQIA requires hospitals query the Data Bank when a physician "applies to be on the medical staff (courtesy or otherwise)" or for clinical privileges. Hospitals must also query the Data Bank every two years concerning any physician on staff or with clinical privileges. Hospitals may request information at other times. 42 U.S.C. ~ 11135(a) (1995).

The Act specifically immunizes hospitals from liability if they rely on false information provided by the Data Bank unless the hospital knew it was false. Id. at ~ 11135(c).) Some restrictions may even have a direct impact on the doctor-patient relationship. Third, ADA regulations and Interpretive Guidance state Title I protections apply to Title II. (28 C.F.R. ~ 35.103(a). See Judiciary Committee Report, H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2, at 84 (1990). But see Jacobs, 1993 No. 93-3670, U.S. Dist. LEXIS 14294, at *14-19, (where the court reviews several regulations which create ambiguity on this issue).) Finally, even if Title I protections are not applicable to all Title II services and benefits, they should apply to professional licensing boards because they are appropriate and necessary. (Many of the specific protections are not necessary for some public services and benefits, such as use of parks and public buildings. Chai Feldblum, Medical Examinations and Inquiries Under The Americans With Disabilities Act: A View From The Inside, 64 TEMP. L.Q. 521 (1991). However, this does not mean the protections should not be available for those services to which they are appropriate.)

The New Jersey medical board recently agreed. The board analogized relicensure to an employment situation, thereby conceding at least some Title I protections apply to its activities. The board's argument for continued use of mental health inquiries on relicensure applications (Jacobs, 1993 No. 93-3670, U.S. Dist. LEXIS 14294.) rested on the hypothesis that obtaining a license is akin to being hired for a job. (Id. at *24.) Committee reports "produce an ambiguous picture" as to whether Congress intended to incorporate Title I "in its entirety" into Title II. (Id. at *26.) Nevertheless, the court avoided deciding the

issue because plaintiff was only seeking a preliminary injunction. (Although the judge determined plaintiff had a high probability of success on the merits to invalidate mental health inquiries, the preliminary injunction was denied absent a showing of irreparable harm. Id. at *27, *32.)

IV. BOARD DECISIONS

A few egregious decisions illustrate that some boards are victims of the prejudice against sick people that the ADA was enacted to prevent. Boards make this mistake at each point in the process. (Initial licensing decisions are beyond the scope of this article. See Coleman & Shellow, supra note 4.) This is particularly troubling because, as is generally true, regulatory agencies and licensing boards which act for them are granted great deference. (Physician, Heal Thyself, supra note 9, at 1080.) As a result, board decisions are upheld unless arbitrary and capricious or a clear abuse of discretion. (See, e.g., Borden v. Division of Med. Quality, No. 0018801, 1994 Cal. App. LEXIS 1239, *20 (Cal. Ct. App. Sept. 7, 1994).

A board abuses its discretion if it "'has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.'" Williamson, 266 Cal. Rptr. at 522 (quoting ~ 1094.5(b) Calif. Code of Civil Procedure).) Some board decisions exceed even this broad scope. Although these bad results would probably be reversed if challenged, they still cause unnecessary harm: the physician suffers without compensation and the public does not benefit.

For example, in one particularly outrageous case, the Arkansas medical board imposed a one year probation based on a physician's attempted suicide. (Arkansas State Medical Bd. v. Young, No. CA 93-905, 1994 Ark. App. LEXIS 407, *5 (Ark. Ct. App. Sept. 7, 1994).) The board contended Dr. John Young's suicide attempt constituted "unprofessional conduct by becoming physically or mentally incompetent to practice medicine to such an extent as to endanger the public." (Id. at *3. Arkansas statutes permit the board to sanction a physician for such unprofessional conduct. Id. at *2-3 (citing Ark. Code Ann. ~ 17-93-409 (10) (1987). The board initiated the disciplinary proceeding when Dr. Young admitted he attempted to kill himself by overdosing on a antidepressant. Id. at *2).) However, the board failed to produce any evidence that the suicide attempt rendered Dr. Young incompetent so as to endanger the public. Indeed, the only evidence the board presented was Dr. Young's admission of his serious suicide attempt and hospital records stating he had been found at home after taking an undetermined amount of drugs.

In contrast, Dr. Young introduced evidence to show he was competent and not a danger to the public. He testified since his suicide attempt he had been treated by a psychiatrist and continued to receive therapy from a psychologist. Dr. Young also testified he had not returned to work until his therapist approved, "had never had a drug or alcohol problem, that he is not on any medication, and that he has never done anything which would harm a patient." (1994 Ark. App. LEXIS 407 at *4.) In addition, he assured the board he was no longer suicidal and was "glad to be alive." (Id.) Letters from his psychiatrist, psychologist, and five other physicians fully supported his testimony.

Thus, according to the court, the "undisputed evidence presented" was that Dr. Young was competent. (Id.) Nevertheless, the board placed him on probation. Even worse, when Dr. Young successfully petitioned the circuit court to set aside that decision, the board appealed, further delaying resolution. For almost three years, (Dr. Young attempted suicide in January, 1992. The Arkansas appellate court did not decide until September, 1994, that-without more-using the suicide attempt as the basis for probation was improper. Id. at *4.) Dr. Young's professional status was unclear because a state medical board based its decision on outdated myths and stereotypes about mental illness.

A Florida case illustrates a board's inappropriate use of disciplinary action from another state and a "gross abuse of its discretion" in denying a license. (Nest v. Department of Professional Regulation, 490 So. 2d 987, 988 (Fla. Dist. Ct. App. 1986).) Dr. M. Carl Nest had voluntarily surrendered his New York license in 1979 after attempting, while intoxicated, to treat four patients. He moved to Florida and eventually successfully completed treatment for his alcoholism. (Id. He also passed a national medical examination which was a requirement for a license in Florida. Id.)

The Florida board responded to Dr. Nest's application for licensure by requesting reports from his physician and requiring an independent evaluation. Despite recommendations by both that Dr. Nest be granted a license conditioned on treatment and attendance at AA, the board rejected his application. (Id. at 989.) The final order "relied exclusively" on Dr. Nest's New York experience to conclude he had failed to demonstrate his ability to practice with skill and safety. The order provided he could reapply in Florida if his New York license was reinstated. (490 So.2d at 988.)

Dr. Nest attended a University of Florida School of Medicine clinical refresher course. He also contacted the "'Doctors' Recovery Network'" and joined their International Doctors of Alcoholics Anonymous group. He requested and was granted a formal hearing. In an extensive pre-hearing stipulation, the parties agreed there was "no dispute regarding Dr. Nest's qualifications for medical licensure in Florida, or regarding the adequacy of his clinical skills, except insofar as his past alcohol impairment impacted on those skills." (Id.) All doctors who had treated or evaluated Dr. Nest, including a member of the Florida Medical Association's Impaired Physician's Committee, plus several experts in drug and alcohol treatment, testified he could practice with skill and safety. Without introducing any contradictory evidence, the board rested its case. (Id.)

The hearing officer concluded that "Dr. Nest had amply demonstrated his ability to practice safely, [and] ... recommended he be licensed and placed on two years probation." (Id. at 989. The hearing officer conceded the board had discretion to deny the license because Dr. Nest's past impairment constituted statutory grounds for discipline. Nevertheless, he concluded denying the license would be an abuse of discretion. The statute requires the board to permit impaired physicians to prove they can return to practice without risk to patients. 490 So.2d at 989.) Despite the board counsel's strong recommendation that the hearing officer's order be adopted, the board altered the hearing officer's findings of fact and conclusions of law and denied the application. (Id.)

The Florida appellate court reversed. The ability to practice safely is ultimately an issue of fact.

Therefore, because "competent substantial evidence in the record" supported the hearing officer, the board was not free to replace these findings with its own. (Id.) Because the record contained no evidence that Dr. Nest could not practice safely-and because the hearing officer, the board's lawyer and consultant all recommended licensure-denial "can only be characterized as an abuse of agency discretion." (Id. at 990.)

This board's stubborn refusal to focus on current ability to practice with skill and safety in favor of a myopic fixation on past addiction is puzzling.

A North Carolina decision provides an example of abuse of discretion in denying a physician reinstatement of his license. (In re Magee, 362 S.E.2d 564 (N.C. App. 1987).) Dr. Archibald Carter Magee's license was automatically suspended when he was adjudicated mentally incompetent. The adjudication was based on his plea of not guilty by reason of insanity. This plea to a criminal assault charge was accepted and, due to his drug and alcohol abuse, Dr. Magee was involuntarily committed to a psychiatric hospital. (Id. at 565.)

After months of hospitalization, Dr. Magee was found competent and released. He sought reinstatement of his license. Even though Dr. Magee responded to the board's request and submitted psychiatrists' statements of his mental competence, his application was rejected. (Id. The psychiatrist he was seeing at the time recommended licensure with conditions, such as regular attendance at AA for life and outpatient psychiatric treatment for one year. Nevertheless, without notice or a hearing, the board refused to reinstate Dr. Magee's license. Id.

Dr. Magee's request for a formal hearing was granted. But, despite testimony concerning his mental competence and efforts at rehabilitation, the board refused reinstatement based on his history. On review, the court ordered the case remanded for hearing de novo in accordance with procedures the board should adopt. 362 S.E.2d at 565. After judicial review remanding for a board hearing de novo, a signed order concluding Dr. Magee's constitutional rights had been violated and an amended order, both sides appealed. However, because Dr. Magee failed to properly raise or argue his assignments of error, the court considered only the board's issues. Id. at 566.)

The appellate court found the board denied Dr. Magee procedural due process. (Id. at 566-67.) The board led him to believe reinstatement depended on proof of mental competence but rejected his application on three other grounds, without giving Dr. Magee notice or meaningful opportunity to be heard. The court also disagreed with the board's claim to "complete statutory discretion to deny or limit" a license once a doctor's practice has been terminated. (Id. at 567.) The court remanded to the board for a hearing de novo because "nothing" in the statutes "would allow the Board to continue, either permanently or indefinitely, the deprivation of a license, begun as an automatic suspension for mental incompetency, upon totally different grounds, without notice of those grounds or an opportunity to be heard." (362 S.E. 2d at 568.)

Most of the cases predate the National Practitioner Data Bank. As more information about license

restrictions becomes available, an increase in bad results is predictable.

V. IMPAIRED PHYSICIANS

(The first national discussion of impairment caused by alcoholism and drug abuse occurred during a 1975 AMA symposium. At that time only five states had impaired physician programs. All five were completely volunteer. By 1988, every state had some sort of program. S. Lon Connor, Comparison of Impaired Physician Programs Nationwide, 37 MD. MED. J. 213 (1988).)

Boards must stop confusing illness with impairment when imposing restrictions. (The AMA Model Impaired Physician Act avoids this trap. The model legislation "clearly distinguishes impairment caused by alcoholism, drug abuse, or mental illness from professional incompetence." The Impaired Health Professional, supra note 35, at 259.

A recent AMA Council on Medical Education Report also recognized that the issue is impairment. The Council recommended physician evaluations "inquire only into illness or disabilities that may reasonably be expected to affect a physician's current competence to practice medicine." Hugh E. Stephenson, Jr., SELF-INCRIMINATING QUESTIONS ON LICENSING APPLICATIONS, AMA COUNCIL ON MEDICAL EDUCATION REPORT 10, I-94 at 5 (amending Policy 275.978(9)).) Physicians who suffer from illness are sick. They are not necessarily impaired. Impairment involves "the loss of a function, where a person's ability to practice is diminished in value, strength, quality, or excellence." (The Impaired Health Professional, supra note 35, at 252.) In other words, a sick doctor is only an impaired physician when his illness adversely affects his ability to practice. A physician's license should only be restricted if he is impaired.

Impaired physician programs (Although most programs include psychiatric disorders, many devote more attention to substance abusers. For example, in Kentucky, seven (5.2%) of the 134 physicians referred to the Impaired Physician's Committee (IPC) between 1979 and 1990, were referred based solely on psychiatric problems. These included "schizophrenia, paranoid depression, or manic-depressive disorders." Richard D. Blondell, Impaired Physicians: The Kentucky Experience, 90 J. KY. MED. ASS'N 62, 65 (1994). An additional six physicians (4.5%) were referred because of "possible organic impairment (e.g., dementia)." Id. These data obviously predate the 1990 ADA. Persons suffering from all these illnesses now enjoy the Act's protections. The great majority of referrals (107 doctors representing 81.3%) resulted from suspected substance abuse. Id. The ADA expressly excludes current substance abusers.

Other jurisdictions agree "chemical dependency remains the leading cause of impairment." However, they report a greater percentage-between 6 and 20%-of "[i]mpairment due to mental illness without concurrent chemical dependency." David G. Benzer, Healing the healer: a primer on physician impairment, 1991(2) WIS. MED. J. 70. According to Dr. Benzer, the director of the Wisconsin impaired physician program, "[i]t is unclear" whether the disparity results from "a lesser incidence of psychiatric illness as the source of the impairment ..., or less willingness on the part of colleagues to report

physicians with psychiatric illness." Id. Interestingly, Dr. Benzer reports approximately the same percentage (82%) of physicians involved in the Wisconsin program because of substance abuse problems. Id. at 73.

Dr. Benzer raises another important issue. Although physical illness is correctly included in the AMA definition of impairment, most of the literature ignores physical disorders. Id. This omission is revealing. It supports and perpetuates myths about and prejudice against the mentally ill.

In fact, two-thirds of the 30 state society programs responding to a 1986 AMA study treat some major psychiatric disorders. The Impaired Health Professional, supra note 35, at 254 (citing E. Steindler, Impaired Health Professionals: State of the Art, 36 MD. MED. J. 217 (1987)). Nevertheless, the focus continues to be substance abuse. Id. It is interesting to note some states have developed programs for "compulsive gambling, sexual exploitation of patients, and treatment of general psychiatric disorders without substance or alcohol abuse." Id.

Further, programs which focus only on substance abuse are losing an opportunity to help more physicians who are in trouble. According to at least one commentator, despite a "relative paucity" in the literature of information concerning physician recovery from mental illness other than substance abuse, "in general the prognosis and recovery rates are worse than for chemical dependency." Michael Centrella, Physician Addiction and Impairment-Current Thinking: A Review, 13(1) J. ADDICTIVE DISEASES 91, 98 (1994). This raises the question whether the apparent gap in providing assistance creates the disparate results. Alternative explanations include that the prognosis and recovery for substance abusers is generally higher or that intervention is usually more successful.) serve two critical functions: 1) protecting the public welfare and 2) restoring sick colleagues to good health. (Emmanuel M. Steindler, Impaired Health Professionals: State of the Art, 36 MD. MED. J. 217 (Mar. 1987). All states have established an impaired physician policy and committee. Centrella, supra note 126, at 100. Impaired physician treatment programs were created to assure patient welfare. Another goal "of equal importance" is "saving the life of colleagues and restoring them to good health both personally and professionally." Id. at 101.) Medical professionals have other reasons to create and implement these programs for colleagues. By helping assure physician competence and reliability, they maintain and enhance professionalism. (The AMA Council on Mental Health suggests organized medicine's "paramount responsibility" is accountability for assuring competent health care. Council on Mental Health, The Sick Physician Impairment by Psychiatric Disorders, including Alcoholism and Drug Dependence, 223 JAMA 684 (1973). Impaired physicians-doctors "whose functioning has been impaired by psychiatric disorders, including alcoholism and drug dependence"-occasionally jeopardize this responsibility. Therefore, the Council recommended referrals to medical society or board committees created specifically to decide whether the doctor "is suffering from a disorder to a degree that interferes with his ability to practice medicine." Id.

In fact, the Council concluded physicians have an ethical responsibility to be aware of another doctor's "inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or drug dependence." Id.) Further, they preserve the enormous societal investment in the physician's medical training. Programs must "maintain a balance between concern for colleagues as human beings

and concern for public safety." (Steindler, supra note 127, at 220. Emmanuel Steindler, Executive Director, American Medical Society on Alcoholism and Other Drug Dependencies, fears a "swing toward a more punitive climate," makes the balance more difficult; nevertheless, "maintain the balance they must." Id.

Not surprisingly, different types of programs have evolved to respond to this very complex problem of impaired physicians. Edward T. Carden, Whither the Impaired Physician? The Politics of Impairment, 37 MD. MED. J. 206, 206-08 (1988). Controversy continues over the most effective organization. Nine states legislate programs. Of these, two are administered by state boards, or by independent agencies, and three by medical societies which contract with the board. Medical societies administer all remaining state programs. Richard Ikeda & Chet Pelton, Diversion Programs for Impaired Physicians, 152 WEST. J. MED. 617 (May, 1990).

One study evaluated 100 doctors successfully treated in programs of professional psychotherapy and peer-led self help groups. All reported Alcoholics Anonymous was more important to their recovery. See generally Marc Galanter et al., Combined Alcoholics Anonymous and Professional Care for Addicted Physicians, 147 AM. J. OF PSYCHIATRY 64 (1990). No system is perfect. Concern about licensure action may reduce the efficacy of programs administered by state boards. These fears may prevent physicians from joining voluntarily. On the other hand, the close coordination with the licensing and disciplinary board is presumed to enhance public protection.

In contrast, medical society programs are seen as more effective because doctors do not feel threatened by board action. They also enjoy confidentiality. For example, in Kentucky the purpose of the Impaired Physicians Committee (IPC) "is to help the physician." Blondell, supra note 126, at 64. IPC responses depend on circumstances. The physician appears at a regular committee meeting. If he decides the IPC can help him, they enter into a "contract." Although not meant to be legally binding, it "outlines the relationship between the physician and the IPC and acts as a mutual commitment to the physician's continuing recovery." Id. Participation is voluntary, but most cooperate.

Although the goals and methods of the IPC are complementary to those of the state medical board, some sharp distinctions exist. The fundamental difference is function. The board's duty is to protect the public. Therefore, the impaired physician's involvement is mandatory. The board must provide due process rather than act, as the IPC may, on hearsay. The good working relationship between board and IPC benefits both the impaired physician and the public. Id. This means impaired physicians are likely to join sooner. However, the perceived problem with these programs is boards and the public may believe information is insufficient to insure public safety. Ikeda & Pelton, supra note 129, at 617-18.

Ironically, in light of this recurring controversy, discussion at a national program director's conference led to the conclusion that "the different models of organization did not appear to be the overriding factor in making a program effective.... The major factor was how organizational agencies representing the

different entities worked together. In states where these agencies have developed trust and mutual respect, the programs work well indeed." Id. at 618.)

Unfortunately, impaired physician programs and committees frequently fail to distinguish between sick and impaired doctors. Perhaps part of the difficulty results from the name "impaired" physician program. Although participants may be sick, many are not impaired. Both sick and impaired doctors might benefit from, or even need, treatment, but the issue for licensing boards is only the effect of the physician's illness on his patients. As a result, the public interest-and thus the board's-is very different depending on whether the sick doctor is also impaired. Certainly, for his own well being any physician whose illness requires treatment should get help-either from an impaired physician program or appropriate professional. However, the only reason for a board to require treatment or restrict a doctor's license is if his illness affects his patients.

On the other hand, when an illness-or any other problem-affects the physician's ability to practice with skill and safety, he is impaired. At this point, the medical board-the public's protector-has an interest, maybe even the duty, to insure the physician receives treatment. (So, for example, the Committee on Impaired Physicians in Rhode Island will not intervene until the doctor's illness affects his professional activity. However, when substance abuse is the disease, "waiting for professional impairment would be comparable to waiting for cancer to metastasize before initiating treatment." Herbert Rakatansky, Special Report, The Committee on Impaired Physicians of the Rhode Island Medical Society, 68 R.I. MED. J. 119, 119-20 (Mar. 1985). This is because every area of a doctor's life-"family, community relationships, and financial affairs-is affected adversely before the professional aspects." Id. at 120.

Nevertheless, of 100 physicians in continuing care contracts with the Georgia Impaired Physicians Program, 26 percent reported state medical license problems at the time of admission into the program. Thirty-seven percent reported a problem with their drug enforcement license status. Karl V. Gallegos et al., Relapse and recovery: Five to ten year follow-up study of chemically dependent physicians-The Georgia experience, 41 MD. MED. J. 315, 317 Table 3 (Apr. 1992).)

VI. CONCLUSION

Locked into their anachronistic and discriminatory notions, medical boards improperly and illegally equate certain illnesses with impairment. Board practices are anachronistic because they shun medical epidemiology defining mental illnesses and substance abuse disorders and ignore the infrequency of impairment associated with these diseases. Decisions are discriminatory because current solutions are based on disability. Not only are such decisions morally reprehensible and not responsive to the very real problem of bad doctors, they violate the ADA.

People with disabilities are now a suspect class. Licensing or certifying procedures which relegate the disabled to "lesser ... opportunities" by "limiting" them based on disability must be narrowly tailored to protect the public from physicians who fail to practice with skill and safety. Instead, some boards tenaciously cling to their outdated prejudices against people suffering from mental disorders. As doctors,

they should know better.

The system is further complicated by an elaborate reporting system-the Federation, the National Practitioner Data Bank, and direct communication among the boards. Reporting license restrictions based on professional incompetence and misconduct is critical in assuring quality medical care for all Americans. Reporting illness-based limitations does little to protect the public and is a substantial invasion of the physician's privacy and a violation of the ADA. Further, some boards misunderstand and misuse the information.

The solution is clear. Boards must impose and report conditions based on impairment or behavior rather than illness and obey the ADA mandate to end discrimination against sick people.

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