Serious Ethical Violations in Medicine

Dealing Effectively with Outlier Peers

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Conflicts of Interest

I have no relevant financial conflicts of interest

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Physicians are not like other professionals

It is legal, common, and necessary for physicians to

- Cut patients
- Provide patients with opioids and psychotropics
- Ask patients to undress and touch them

The Work of My Team

NIA R01: 280 Cases

- Unnecessary surgeries
- Criminal prescribing
- Sexual abuse of patients

ORI/NCRR: 100 Cases

- Clinical Research and Practice

Greenwall Foundation: 40 SMB Members on Delphi consensus panel

Most physicians behave appropriately, but …

Let’s review just a few of the 380 cases our team studied

Manzella

An infectious disease doctor, wrote fraudulent prescriptions to obtain thousands of oxycodone pills for a New Jersey con man who sold them on the black market. Greed appeared to be the motive. Manzella worked with a lack of oversight in a private practice with his brothers who did not know about the scam (Hall 2013).

Nally

wrote prescriptions for patients who would then fill them and return half of the filled prescriptions to Nally for her use (Commonwealth of Kentucky 2012).

Glaser

performed at least 90 unnecessary cardiac catheterizations for financial gain. Nurses complained that Glaser was sleeping in patient rooms and operating on patients 18 to 21 hours a day. Their complaints were ignored by hospital administrators (Holdren 2015, White 2015, 2016).

Blankenburg

Pediatrician co-owned a practice with his brother where he gave drugs and money to adolescent boys after he performed sex acts on them to convince them to stay quiet (2012)

Hung Do

General practitioner fondled the breasts and vaginas of several patients; the touching had nothing to do with appropriate examinations. Some instances occurred in front of a chaperone or family member (Guisti 2009)

Effects on Patients

Physical harm … death

Anger, anxiety, depression, avoiding medical care

Costs, lost work

Do You Trust the Medical Profession?

A growing distrust could be dangerous to public health and safety.

By Dhruv Khullar

Jan. 23, 2018

Is this Common?

5/1000 physicians are the subject of SMB disciplinary action annually

1/1000 receive severe disciplinary action (suspension or revocation of medical license)

Number of actual serious ethical violations is unknown.

(More on this later!)

It is Rare, However …

New Cases of Breast Cancer, US	1.3/1000 (CDC)
New HIV diagnoses, US	.14/1000 (CDC)

Outline

I. Research questions
II. Approach
III. Findings
IV. The Difficulty of Making Recommendations
V. Discuss Possible Solutions

I. What Questions Did We Ask?

Why did these cases happen?

What was the duration and impact?

- Physician characteristics
- Motives – broad sense
- Opportunities
- Duration and impact

II. What Was our Approach?

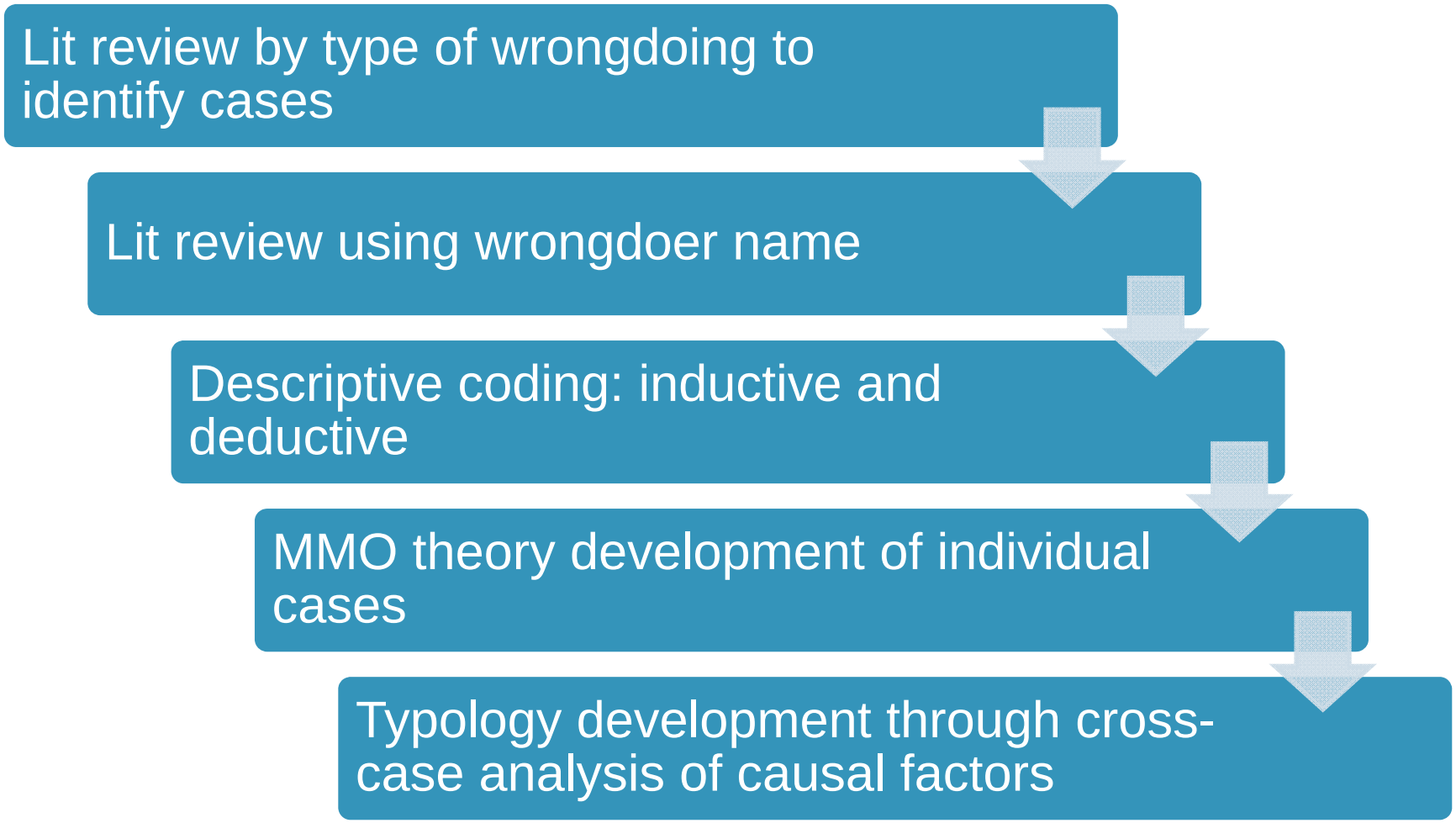
Historical data

Feasible and ethical
Ecological validity
Many variables

Causal analysis can be theory driven

Equifinality

Method Overview for all Samples



III. Big Picture Findings: Motives and Settings

Intentional wrongdoing	99%
Males	95%
Non-academic settings	95%
Selfish motive (e.g., sex or money)	90%
Problems with oversight (lack or failed)	89%
Suspected personality disorders	51%

(N=280)

Big Picture Findings: Duration and Extent

Repeated instances of wrongdoing	97%
Duration > 2 years	70%
Duration > 5 years	33%
Case involves >1 kind of wrongdoing	68%
Failed whistleblower attempt (ignored)	20%
Missed opportunities to whistleblow	23%

Comparison with Historical (Hx) Controls

Physician wrongdoer descriptive data vs historical data				
Variable	Hx %	IPCS%	UIP%	SAP%
Non-Academic Setting	93	98	92	94
Solo Practice	13	62	18	39
Board Certified	70	37	71	31
Age >49	47	62	49	57
Male	69	88	96	100
Born Outside USA	27	16	28	16
Trained Outside USA	24	32	40	25
Suspected Antisocial	4 – 6	57	48	31

Typologies Created by Sorting

Primary kind(s) of wrongdoing

- IPCS, SAP, UIP

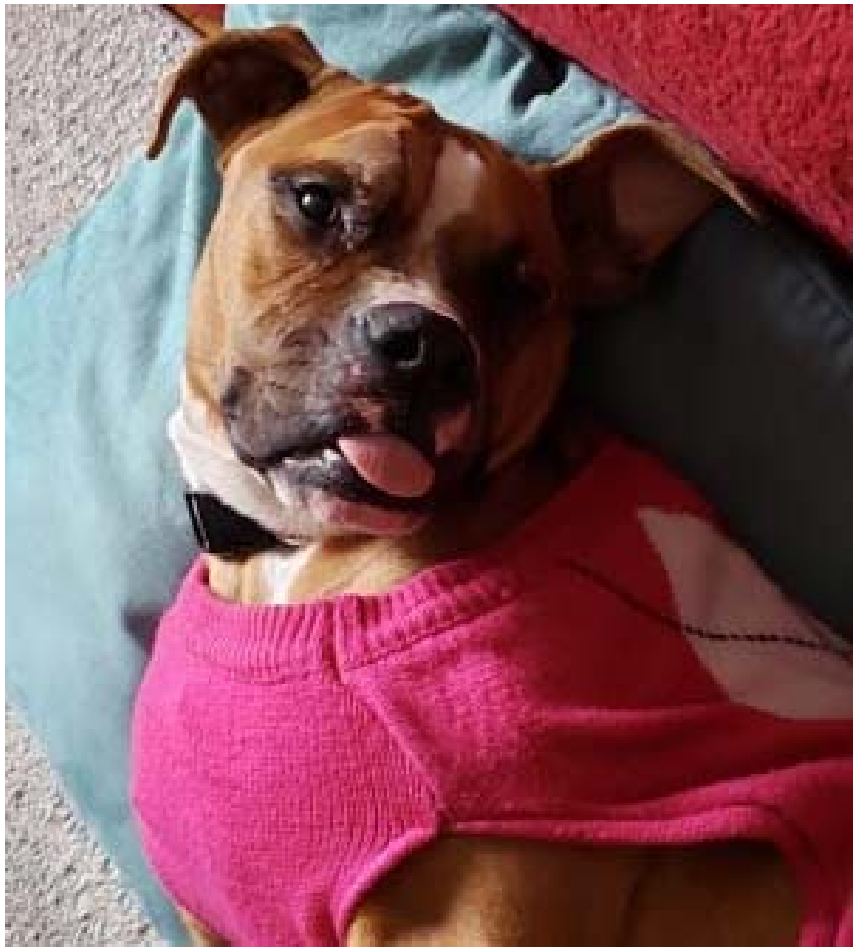
Primary sufficient motive

- greed, sex, coercive sex, poor decision-making

Primary oversight problem

- lack of oversight, oversight failure, corrupt climate, or none

Differences Across Typologies



- Board certification
- Male
- Personality disorders

“Incidental Findings”

- Physicians often remained in practice after first report of wrongdoing
  - AJC (2016-17) studied 450 cases of sex abuse by physicians
  - Half of these doctors remain licensed to practice medicine
- Wide variation across medical boards

IV. Why It is Difficult to Formulate Recommendations

1. Lack of Data
2. Associated factors are weak predictors
3. Prevention comes at a cost

1. Lack of Data

The Example of Sexual Abuse by Physicians

- Underreported by patients
- When reported to institutions/peers, then underreported to boards/NPDB
- Useless NPDB info in 62% of cases (“not specified”)
- NPDB will not share identifiable data
- No one tracks physicians across their careers

2. Why predictive data are only so useful

They are only risk factors:

Most physicians who are male, over 40, or non-board certified, never have serious complaints

Abusers are often charming and well-liked—often no obvious personality flags

3. The Cost of Prevention

Protecting Patients

- Fostering reporting
- Investigations with full history
- Promptly removing harmful physicians

Protecting Physicians

- Privacy
- Due process (protection from false accusations)
- Wasted time, money, energy

V. Exploring Potential Solutions

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Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States From 2008–2016

James M. DuBois, Emily E. Anderson, John T. Chibnall, Jessica Mozersky & Heidi A. Walsh

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Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group

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ABSTRACT: This article reports the consensus recommendations of a working group that was convened at the end of a four-year research project funded by the National Institutes of Health that examined 280 cases of egregious ethical violations in medical practice. The group reviewed data from the parent project, as well

Discussion

When does a physician deserve a second chance?

If the best predictor of serious wrongdoing is past wrongdoing, when should we remove students or residents?

Discussion

How can we ensure that a second chance is not the 265th chance?

Should the NPDB gather detailed info and more broadly share info?

Discussion

Should higher qualifications be required to work in solo practice?

Discussion

Should anything be done about the demographic correlates?

Discussion

How can we advise patients to report violations without victim blaming?

How can we empower patients to protect themselves without undermining trust in medicine?

Discussion

What other measures might prevent serious ethical violations in medicine?

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