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Enforcement of commercial violations by health professional regulatory boards: a research note

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ENFORCEMENT OF COMMERCIAL VIOLATIONS BY HEALTH PROFESSIONAL REGULATORY BOARDS: A RESEARCH NOTE

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ABSTRACT

This paper explores the nature of disciplinary decisions of health professional regulatory boards in response to commercial violations by licensees. Decisions of the Virginia Boards of Dentistry, Medicine and Optometry are analyzed to assess the extent to which disciplinary decisions appear to protect the economic interests of professionals versus the health, safety and welfare of the public. Sanctions imposed on commercial and non-commercial violations are compared. Given the criticism that regulatory boards are more concerned with commercial practices rather than quality of care practices, it was expected that board disciplinary actions would reflect this concern. The results indicate that there is no significant difference in the severity of sanctions imposed on both types of violations. Commercial violations, when compared with non-commercial violations, are not sanctioned more harshly by regulatory boards. The implications for self-interest theories of professional regulation and policies governing commercial practices of health professionals are discussed.

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INTRODUCTION

This article explores the nature of disciplinary decisions of health professional regulatory boards in response to commercial violations by licensees. Decisions of the Virginia Boards of Dentistry, Medicine and Optometry are analyzed to determine the nature of sanctions imposed on commercial violations. Virginia is the focus of the paper because it was one of the first states to evaluate systematically the enforcement function of its health professional boards.

Health professional regulatory boards are state administrative entities responsible for establishing entry and performance standards and for enforcing statutes and regulations governing professional practice. Professionals predominate or comprise the full membership of most boards. Professional norms---economic, ethical and technical---codified in statutes and in board regulations are critical in regulatory board decisions (Bayles, 1987).

Regulatory boards typically rely on three major types of credentialing mechanisms for establishing entry standards: registration; certification and licensure. The least restrictive is registration, which simply requires individuals to register with a state designated agency. Certification allows the use of a title by anyone who meets specified criteria. Certification does not restrict practice per se, but just restricts the use of particular titles associated with that practice. Licensure, the most restrictive form of regulation, refers to the exclusive authority given to individuals who meet specified criteria to practice a profession or occupation (Shimberg, 1982).

Certification, registration and licensure each impose different constraints and consequences on their respective professional groups, with respect to the cost and quality of health care services (Shimberg, 1984). Licensure is the form of regulation most relevant to this analysis of disciplinary

decisions. The professional boards analyzed in this paper impose licensure laws and regulations on the relevant professional group.

PROBLEM

Licensure, the form of regulation most associated with the term regulation for practice to those with the required qualifications to practice. A major criticism is that the monopoly afforded by licensure requirements increases costs with little improvement in the quality of health care service (Gaumer, 1984; Hogan, 1983). In reviewing 97 studies on health professional regulations, Gaumer concluded that easing licensure restrictions would reduce costs without endangering public safety (Gaumer, 1984). Some observers even argue that licensure requirements are detrimental to the delivery of and access to health care services because such requirements decrease the number of practitioners. As a result, the costs of their services are higher (Carroll and Gaston, 1983; Hogan, 1983).

A second criticism of regulatory boards is that they overemphasize control of commercial practices, such as advertising, rather than patient care practices. Regulations such as restrictions on advertising have been criticized for not protecting the public's health, safety or welfare. Critics charge that these regulations' major purpose is to restrict competition, thereby increasing the income of licensed professionals (Cohen, 1980).

Are these criticisms of regulatory boards warranted? Are boards more interested in protecting the economic interests of their colleagues than in protecting the health and safety of consumers? This study attempts to answer these questions by analyzing regulatory boards' enforcement of commercial practice restrictions. Health professional regulatory boards' disciplinary decisions are

made in response to commercial violations are examined.

This study is significant for several reasons. First, empirical data on regulatory board discipline has only recently been made available for analysis. Thus, there are few empirical studies on disciplinary actions by regulatory boards. The results will provide empirical evidence to either support or challenge the long-standing critique of regulatory boards with respect to disciplinary decisions concerning commercial restrictions.

Second, this study's focus on one state and several boards provides a comparative basis to analyze disciplinary outcomes of regulatory boards in other states. Thirdly, in addition to medicine, this study includes dentistry and optometry, which have received almost no empirical study of their disciplinary decisions. Finally, although considerable research has been done on the relationship between licensure and commercial practices, a similar effort has not been directed toward an empirical examination of the enforcement of commercial practice restrictions (for example, see Begun, 1981; Gross, 1984).

OVERVIEW OF HEALTH PROFESSIONAL DISCIPLINE IN VIRGINIA

The administrative home of the boards is the Virginia Department of Health Professions, which the Department provides administrative support for the regulatory function of the boards. The boards have the sole authority and responsibility for licensing, regulating and disciplining licensed health professionals in Virginia. Complaints investigated by the Department are forwarded to each board to decide whether there is sufficient evidence to support the allegation of a violation. If the boards determine there is sufficient evidence, they will conclude that a violation of a statute or regulation has occurred and impose a sanction. If the evidence is deemed insufficient, the complaint

is dismissed. Consequently, considerably more complaints are received and investigated by the department than the resulting number of violations and sanctions.

State statutes provide general authority to all professional and occupational boards in order to regulate and discipline practitioners; the statutes grant boards the authority to act to protect the public. This general authority is supplemented by specific statutes and regulations for each respective board. The general powers and duties of all health professional boards include the authority to: (1) revoke, suspend, restrict or refuse to issue or renew a registration, certification or license which such board has authority to issue for causes enumerated in applicable law and regulations, and; (2) take appropriate disciplinary action for violations of applicable law and regulations (VA. CODE ANN. §54.1-2400, 1984).

The authority to discipline practitioners is further defined in each board's statutes and regulations. The penalties boards may impose for violations of statutes or regulations include monetary penalties as well as restrictions on the right to practice. The boards in Virginia are authorized to impose monetary penalties of up to $1,000 provided the licensee does not face criminal prosecution (VA. CODE ANN. § 54.1-2401). In addition, criminal penalties maay be imposed if violations of statutes or regulations of Title 54 are Class 1 misdemeanors and are repeated violations (three or more within 36 months), they constitute a Class 6 felony.

RESEARCH METHODS

The conceptual framework is derived from self-interest theories of professional regulation. Within this theoretical formulation, professionals dominate regulatory inputs and outcomes by "capturing" the regulatory mechanisms (Meier, 1985). Most professional regulatory boards for

example, are composed solely of professionals. The few states which allow non-professionals to sit on regulatory boards typically prevent them from voting on licensure or disciplinary matters. Professionals may impose restrictions on entry into the profession, and impose other ethical obligations which limit competition.

If boards are dominated by the regulated professions and if the regulated professions adopt monopolistic policies and practices, then we would typically expect discipline to further complement such policies and practices. Within the regulatory sub-system, the boards function in isolation from other factors--such as consumer advocacy--which might serve to mitigate the tendency to protect the interests of the profession. Protecting the interest of the profession, however, does not necessarily conflict with protecting the interests of the public and the consumer. Therefore, we might find that even though regulatory board actions further practitioners' interests, the public and consumers' interests are adequately protected.

The analysis of disciplinary decisions builds on one of the first studies to examine disciplinary decisions at the state level---Schneider's 1987 study "Influences on State Professional Licensure Policy." Schneider's disciplinary categories of "strong" and "weak" were broadened to include three major types of discipline available to regulatory boards: punitive, rehabilitative and symbolic. These categories reflect both the degree of severity of sanctions as well as the approaches to discipline that boards may take.

1. Symbolic sanctions indicate deviation from acceptable board standards, but do not limit the right to practice. Examples include letters of warning, reprimands and cease and desist orders.

2. Rehabilitative sanctions are measures designed to improve the practitioner's capability for safe practice, and include measures such as a continuing education requirement, special supervision

for a specified period of time or referral to substance abuse counseling.

3. Punitive sanctions limit the practitioner's freedom to practice. Included in this category are license suspensions, license revocations and financial penalties.

The data analyzed were collected by the Virginia Department of Health Professions for their Complaint Tracking and Reporting System. Complaints of alleged violations are entered into this system and tracked through the investigative and adjudicative phases of complaint resolution. Descriptive statistics of complaints, violations and board findings were generated using the Statistical Package for the Social Sciences (SPSS). The following hypothesis was tested using chi-square analysis and lambda:

> Health professional regulatory boards are more likely to apply punitive sanctions to commercial violations than non-commercial violations.

This hypothesis tests the extent to which trade restriction violations differ significantly from other types of violations, in terms of sanctions imposed by the boards. The results will provide the empirical evidence to support the claim that professional regulatory boards appear to give a higher priority to protecting professionals' economic interests than to protecting the public's health, safety and welfare.

RESULTS

The results fail to support the hypothesized relationship between the commercial violations and punitive sanctions. The severity of disciplinary actions is commensurate with the seriousness of commercial practices violations. Thus, there is little empirical evidence that regulatory boards are unduly harsh in responding to commercial violations compared to other types of violations.

In general terms, regulatory boards were found to impose similar sanctions on commercial

and non-commercial violations. There is no significant difference in the nature of sanctions imposed, regardless of the severity of the violation. Regulatory boards appear to mete out appropriate punishment for commercial violations, given the severity of such violations. The least serious violations receive the least severe sanctions.

Commercial Complaints Received

Sources such as licensees, consumers and professional organizations generated 220 complaints. After reviewing a complaint and the evidence, the boards determine whether there is sufficient evidence to conclude a violation occurred. The boards received considerably more complaints than the number of violations ultimately sanctioned. Of these complaints, only 21 % (n=42) were substantiated as actual violations. That percentage varied among boards, from a high of 34% for the Dentistry Board to a low of 10% for the Optometry Board.

TABLE 1
COMMERCIAL COMPLAINTS RECEIVED AND ADJUDICATED AS VIOLATIONS

Board	Complaints	Violations as % of Complaints	
	#	#	%
Dentistry	62	21	34.0
Medicine	81	13	16.0
Optometry	77	8	10.0

TOTAL	220	42 21.0

Although the overwhelming majority of commercial complaints are unsubstantiated by the evidence, the boards appear to respond appropriately in that the least serious violations are given the mildest penalties. The Department's ranking of commercial complaints in terms of seriousness is shown in Table 2. Each priority code represents the Department's assessment of the danger the alleged violation posed to the public or the consumer. Priority One represents the most serious violations, whereas Priority Three represents violations with no direct threat to the well being of the public or the consumer. Approximately three-fourths of complaints and violations fall into the Priority Three category, according to Table 2.

TABLE 2

PRIORITY RANKINGS OF COMMERCIAL COMPLAINTS AND VIOLATIONS
DENTISTRY, MEDICINE AND OPTOMETRY

Priority Rank	Complaints	Violations
	# %	# %
Priority One	12 5	4 10
Priority Two	50 23	6 14
Priority Three	158 72	32 76
TOTAL	220 100.0	42 100.0

Sanctions Imposed on Commercial Violations

The majority of sanctions imposed on commercial violations fell into the non-punitive category, according to Table 3. Non-punitive sanctions were applied to 80% of the commercial violations compared with 65% of the non-commercial violations. Overall, there is no significant difference in the nature of the sanctions imposed on commercial versus non-commercial violations.

TABLE 3
Type of Violation

	Commercial % #	Non-Commercial % #
Punitive Sanctions	20 (6)	35 (66)
Non-Punitive Sanctions	80 (24)	65 (124)
TOTAL	100 (30)	100 (190)
Chi-Sq. Pr. 1.93 .16		N=220

Individual Boards

An examination of the results for each individual board indicates no support for the hypothesis. The Board of Medicine imposed no punitive sanctions on commercial violations, but imposed punitive sanctions on 34% of the non-commercial violations. The chi-square value of 1.29 with a probability of .26 and a lambda value of zero indicates the independence of these two variables. Although the Board of Optometry imposed more punitive sanctions on commercial violations (86%) than on non-commercial violations (77%), the difference is not significant. The chi-square value of .68 indicates an independent relationship between the two variables.

An analysis of the Board of Dentistry findings, shown in Table 4, resulted in a chi-square

value of 5.30 with a probability of .02, suggesting that the nature of the sanction may not be independent of the nature of the violation. However, the lambda value of zero supports the idea that knowing whether a violation is commercial versus non-commercial does not reduce the error in predicting the type of sanction imposed.

TABLE 4
Association Between Type of Violation and Type of Sanction for Commercial Violations

Hypothesis	Board	Ind.Var.	Dep.Var.	Chi-Sq. Value	Lambda
Hyp. #1	All	Type of [a] Violation	Type [b] of Sanction	1.93	.00
	Dentistry	Type of Violation	Type of Sanction	5.30*	.00
	Medicine	Type of Violation	Type of Sanction	1.29	.00
	Optometry	Type of Violation	Type of Sanction	.16	.00

*p <.05 **p <.01 ***p <.001
a Commercial Violation b Punitive Sanction

CONCLUSION

Commercial violations are more likely than non-commercial violations to receive non-punitive sanctions, except in Optometry cases. The Boards of Medicine and Dentistry both imposed only non-punitive sanctions on commercial violations. Although Optometry imposed more punitive sanctions on commercial than non-commercial violations, there was no statistically significant difference in the nature of sanctions imposed on the two types of violations.

Since three-fourths of commercial violations are categorized among the least serious violations (Priority 3), the boards responded appropriately by imposing milder sanctions. In this

instance, boards do not appear to take a punitive stance toward commercial violations.

Given the extensive criticism of boards' preoccupation with commercial practices rather than quality of care practices, it was expected that board disciplinary actions would reflect this concern. However, the evidence here suggests there is no particular targeting of commercial violations for harsh punishment, at least in terms of the disciplinary decisions of the Boards of Dentistry, Medicine and Optometry in Virginia.

Theoretical assumptions about boards protecting the economic interests of licensees do not appear to be reflected in disciplinary decisions. Perhaps professional' economic interests are a major consideration for a particular profession to impose licensure and entry requirements. However, once these goals are accomplished, economic considerations play a less important role in the enforcement of statutes and regulations governing the profession.

An alternative explanation may be that regulatory boards are sensitized to criticisms asserting that boards have emphasized issues such as restrictions on competition and advertising, and have neglected patient-centered standards of professional practice. The diminished importance of economic concerns may have resulted from attacks on the anti-competitive aspects of professional licensure reflected in Federal Trade Commission decisions, in lawsuits against the American Medical Association, and in state and county medical societies. Federal anti-trust policies and successful anti-trust suits may have had the desired effect of discouraging sanctions of violations related primarily to the commercial aspects of professional practice. As a result, commercial violations may no longer be punished as harshly as they may have been in the past.

Regulations governing advertising and trade practices may not be critical factors in protecting the public's welfare. All of the commercial violations dealt with by these three boards

were classified as among the least serious threats to the public. Furthermore, the second largest group of complaints dismissed were alleged commercial violations. Board and staff time might be better spent exploring consumer concerns rather than investigating and adjudicating allegations of commercial violations.

Health professionals, however, are unlikely to support reduced restrictions on advertising and trade practices. Many argue that regulation ensures high quality care delivered by the most competent practitioners. Such people believe that regulations such as restrictions on advertising are essential to protecting the consumer from misleading information about health care services (Galusha, 1989).

The nature of disciplinary decisions related to commercial violations have policy and administrative implications for health professional regulators. Overall, disciplinary decisions appear to match commercial violations apprpriately; the severity of the penalty is in line with the seriousness of the infraction. However, the extent to which boards should address such violations is still an open question. Given the constraints of limited resources, board members and staff might be more effective if time, money and energy were directed toward patient-centered violations.

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