Out of Bounds: Physician Licensing Board Disciplinary Cases related to Opioid Prescribing

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Abstract: Physician prescribing practices contributed to the US opioid epidemic, leading to increased regulation of opioid prescribing. In some instances, prescribers are unscrupulous or corrupt. They are criminally investigated and subject to prosecution. Less egregious opioid prescribing infractions are addressed through state medical licensing boards. At stake are physicians' licenses to practice medicine.

The first wave of the current US overdose epidemic involved increased prescription opioid mortality in the 1990s, followed by a second wave of increases in deaths involving heroin around 2010.[1] The current third wave is characterized by illicitly manufactured fentanyl driving overdose mortality rates to record highs. Almost half (47%) of persons who inject drugs (PWID) are estimated to have one or more nonfatal lifetime overdoses[2], and 50–58% of PWID report witnessing a prior year fatal or non-fatal overdose of a peer.[3] The current opioid crisis started as a result of an increase in the number of opioid prescriptions caused by overmarketing.[4]

Several mechanisms have been put in place to prevent misprescribing of opioid based medication. These include electronic prescription drug monitoring programs (PDMPs), limits on the quantity of opioids that may be prescribed, compulsory face-to-face examination, medication contracts, drug screening, and pill counts for patients on long-term treatment.[5] Unlike many other areas of medicine, detailed guidelines on opioid prescribing have been incorporated in state statutes.[6] Federal regulations are also used to control opioid prescribing and prevent patient misuse.[7] Whether these are effective in stemming the epidemic and whether they put physicians at risk for unintended legal consequences is not clear.

Medical Practice Standards

Much of the attention to physicians' misprescribing of opioids has been focused on "Pill Mills," or instances when physicians abuse their prescribing privileges and engage in illegal drug distribution.[8] These activities are motivated by physician self-interest — legitimate treatment of patients is absent. These are addressed primarily through the criminal law.[9]

Along with the criminal law, the practice of medicine is regulated by each state's Medical Practice Act (MPA).[10] MPAs outline standards for medical treatment, physician professionalism, and professional ethics and require that a physician's treatment of patients falls within commonly accepted standards of care. Physicians may not provide care that falls below the treatment provided by a "careful, competent" physician or that "departs from or fails to conform to acceptable and prevailing standards."[11] These

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standards of care apply to patient diagnosis, subsequent treatment, follow-up, documentation, and when applicable, final outcomes.[12] Given variations in patient history and diagnoses and multiple potential courses of treatment, this standard must be applied on a case-by-case basis and may require the specialized knowledge of persons familiar with prevailing medical practices.[13] Criminal behavior related to the practice of medicine is a de facto violation of a state's MPA and often precedes final medical licensing board (MLB) actions.

Physician Discipline

Allegations of physician practices falling outside of the accepted standard of care are adjudicated by MLBs. Created by each state's MPA, MLBs provide a mechanism for review of cases by physician peers who are familiar with prevailing medical standards. Some MLBs also include community representatives.[14]

Evidence suggests that concerns about potential entanglement in legal processes related to alleged opioid misprescribing make some physicians reluctant to prescribe opioids. This can result in the under-treatment of pain and/or reluctance to treat patients with pain or opioid use disorders.

State MLBs can apply a variety of sanctions, or orders, in physician disciplinary cases. At their least severe, official board orders range from issuing a public letter of reprimand to requiring a physician to complete continuing education courses. At their most severe, MLB orders may limit, suspend, or even revoke a physician's privilege to prescribe controlled substances, and at the most extreme, may preclude them from practicing medicine entirely.

Although incompetent medical providers should never provide care, the consequences of a Board's determination that a physician acted outside of treatment standards can be devastating for the provider.[15]. Besides jeopardizing his or her professional standing, disciplined physicians may lose hospital practice privileges, fail to meet requirements for further employment, be deemed high risk for malpractice insurance, and/or be barred from billing patients under public insurance. In all US states, physicians who engage in anything deemed to be the practice of medicine after their medical license is revoked commit a crime.[16] Indeed, the Federation of State Medical Boards (FSMB), the professional organization representing MLBs, recommends that practicing medicine without a license be a felony offense.[17] Even when an MLB concludes that a physician's practices were within standards of care, being investigated for a license infraction can be costly, time consuming, and unnerving.[18]

Cases on the Margins and Physicians' Concerns

Evidence suggests that concerns about potential entanglement in legal processes related to alleged opioid misprescribing make some physicians reluctant to prescribe opioids.[19] This can result in the under-treatment of pain and/or reluctance to treat patients with pain or opioid use disorders.[20] For the average, law-abiding physician, this apprehension is not likely to stem from concerns about being "caught" for engaging in intentional, criminal wrongdoing such as operating an illegal drug distribution enterprise; instead physicians may be concerned about inadvertently violating, or being perceived as having violated, opioid-related laws and MPAs.[21] Of particular concern may be the possibility that a physician could be sanctioned for a prescribing irregularity because of a patient's, not the physician's, misuse of controlled substances. In the traditional American Medical Association's "4-D" classification of physician misprescribing, that physicians are "dishonest," "dated," "disabled," or "duped,"[22] these physicians are "duped" — they fail to identify drug-seeking patients. Their oversight does not rise to the level of criminal intention or "willful blindness," but it falls below minimum, accepted practice standards. Yet physicians are notoriously poor at detecting patient malingering or deception, and efforts to do so could undermine trust within the physician-patient relationship.[23]

As an alternative to the "4-D" framework, Dineen & DuBois in 2016 offered a framework organized around "3 C's"; physicians are "corrupt," "compromised," or "careless." The "duped" category is replaced by carelessness or failure to maintain minimum accepted practice standards.[24] The authors emphasize that cases should only be assigned to the "careless" category when a physician's actions or failure to act are repeated or amount to a pattern of behavior rather than a single oversight or error.

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Although studies suggest that physician discipline cases related to opioid prescribing are rare,[25] as are physician discipline cases in general,[26] misprescribing controlled substances is one of the leading causes of physician disciplinary actions.[27] Fear about inadvertently running afoul of opioid prescribing laws and regulations appears to affect practice.

Previous Analyses of Disciplinary Cases

A number of studies have examined MLB physician disciplinary actions and criminal prosecutions related to misprescribing controlled substances including opioids.[28] Most examine criminal cases or cases where resulting MLB orders are the most severe, such as license suspension, license revocation, or surrender in lieu of revocation.[29] Fewer studies have examined the relatively less severe infractions that may concern physicians because their deviations from standards of care are inadvertent or based on unique case characteristics rather than willful behavior involving extreme, more easily detected prescribing.[30] Even fewer studies report on data collected within the previous decade. With the implementation of PDMPs in all but one state in the US, thus increasing opportunities for review of physicians' prescribing practices, up-to-date analyses of cases are critical.

As part of a multi-state study of the influence of laws and policies related to the prescribing of controlled substances on the drug use behavior of persons who use illicit drugs, we examined opioid-related physician disciplinary cases in three US states.

Methods

We examined formal physician disciplinary proceedings in three diverse US states — Connecticut, Kentucky, and Wisconsin. Disciplinary proceedings involving both Medical Doctors and Doctor of Osteopathic Medicine were included. Records were collected for the five-year period from January 1, 2014–December 31, 2018 from board order reports published on each state's website. These reports indicate the MLBs' findings of fact, conclusions of law (i.e., the specific violation of the state MPA), and the MLB orders or sanctions.

Case Inclusion Criteria

Cases were included if there was an MLB case report available for an event or events related to opioids, the opioid-related event took place in Connecticut, Kentucky, or Wisconsin, and the event occurred between January 1, 2014–December 31, 2018. Cases based on an opioid-related event or events that took place prior to 2014 were excluded, although an MLB inquiry, hearing, order, or follow-up order may have extended into the study timeframe. Where multiple records addressed a single or closely related event, these were treated as a single case. When a physician was involved in two or more unrelated events within the study timeframe, these were treated as separate cases, although sanctions for the second case were often influenced by the first case. All other cases were excluded.

Because final MLB board orders are a matter of public record, the study was not subject to Institutional Review Board approval. The larger study of which this was a part was, however, reviewed by Institutional Review Board at the fourth author's institution and was determined to meet legal and ethical standards for research involving human subjects.

Data Analysis

Relevant features of cases were entered into an Excel database. These included characteristics of providers, case characteristics, source of complaint, and resulting MLB orders or sanctions. The data were analyzed through a combination of iterative, open coding processes,[31] and the application of codes developed in previous studies of physician disciplinary cases. (See e.g., FSMB, 2018b[32], Clay, 2003[33], Goldbaum, 2008.[34]) Although at times the case report might suggest something that was not directly stated (e.g., that an individual was running a "pill mill" or a particular patient was diverting opioids) we were careful not to apply our own interpretation of events and reported instead only that which was explicitly stated in the case report.

Case Descriptors

Physician Characteristics

Gender, type of medical degree (i.e., MD or DO), and primary type of medicine practiced were recorded for each case. For analysis, practice areas were combined into nine categories: family or internal medicine; emergency medicine; psychiatry; pain management; obstetrics/gynecology; occupational medicine/physical medicine and rehabilitation; pediatrics; surgery; neurology; and other (**Table 1**).

Case Characteristics

For analysis, physician's actions underlying board conclusions were divided into ten categories: failure to diagnose appropriately; failure to treat appropriately; failure to educate patient/procure informed consent; failure to manage opioid patients appropriately; failure to maintain records; prescribing outside of physician-patient relationship; self-use; failure to heed indicators of patient abuse or patient drug diver-

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sion (when explicitly stated in report); inappropriate delegation of prescribing privilege; and opioid-related criminal allegations (**Table 2**). Because disciplinary actions most often involve several deviations from practice standards, each was included in case characteristic counts separately.

Source of Complaint

When the information was provided, we noted how licensees came to the attention of the MLB. These were also divided into ten categories ranging from routine prescribing reviews (some prompted by previous cases involving the physician), information from law enforcement including coroners, and complaints by other medical providers or the patient or family members themselves. When cases came to the attention of the MLB from more than one source, we selected the earliest source. When no information on how the case was detected was provided, this was indicated (**Table 3**).

MLB Orders

MLB Orders were also grouped into ten categories: license revocation or surrender/voluntary retirement; license suspension; license restriction; continuing medical education; professional assessment and remediation; physician supervision; substance use disorder treatment and abstinence; monetary fine; and reprimand (**Table 4**). MLB disciplinary orders are most often applied to cases in combination. Consistent with our coding of case characteristics, each was coded as a discrete order.

In cases where a physician was deemed to be a potential risk to the public, immediate, ex parte emergency suspensions were ordered until the case went through investigation and adjudication processes. We noted when this occurred but did not include these as separate cases unless this was the only Board action taken. In some instances, Board actions against a physician would be taken because he or she failed to comply with previous orders. These were not included in case counts.

Case Categories

We developed three mutually exclusive categories to describe disciplinary cases — those that involved *misprescribing* — actions that didn't extend over a long time period, didn't involve large numbers of patients, and weren't indicative of a pattern of misfeasance; those that involved *overprescribing* — more serious infractions, often criminal, that involved larger amounts of opioids prescribed to large numbers of patients and/or over an extended time with evidence of a pattern of malfeasance; and those that involved *self-use.*

Results

Overview

We identified 140 opioid-related actions across the three study states over our 5-year study period. Connecticut recorded 27 actions (19%), Kentucky recorded 75 (54%), and Wisconsin recorded 38 (27%). Historically, more physician disciplinary actions of any kind are reported in Kentucky than in Connecticut and Wisconsin.[35] This appears to be consistent for opioid-related cases as well.

Nature of the Case Reports

The level of detail provided in case reports varied widely between states. Connecticut's case reports were brief and provided minimal detail about the circumstances surrounding the allegations or the process to case resolution. Detailed facts of cases, sources of complaints, and investigative procedures were not typically described. Physicians' subsequent meetings with the MLB to be returned to full practice privileges and compliance or noncompliance with orders were also rarely presented. Wisconsin's case reports, on the other hand, were more detailed. Patient visits were described and physicians' actions and concerns as noted in patient charts (or information missing in charts) were outlined. Information on case context was typically provided allowing the complaint source and circumstances leading to the complaint to be identified. Interim hearings before the MLB and compliance with orders were also provided as these developed. Kentucky's case reports provided the most detail. Outside consultants performed chart reviews based on consistent criteria. Consultants' impressions of the physician's activities were often provided, as were, on some occasions, the chart evaluations themselves. Kentucky also provided investigative details such as information from interviews conducted and, in some cases, the physician's response to the charges and perspective on the circumstances prompting them. Like Wisconsin, Kentucky case reports provided sufficient details to identify how the physician came to the attention of the MLB and subsequent compliance with orders and interim MLB hearings with the physician.

Characteristics of Physicians Disciplined

Table 1 describes the characteristics of physicians involved in formal disciplinary MLB hearings. The majority of physicians disciplined in opioid-related cases were male (87%, 122) and practiced allopathic medicine (94%, 132). Well over half of the physicians practiced general, family, or internal medicine (61%,

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85). For comparison, in 2012, 64.4% of physicians in the US were male, 91% practiced allopathic medicine, and most of those with specialties were certified in family, general, and/or internal medicine.[36] Within our sample, the next most represented specialties were pain management with 10 cases (7%) and psychiatry with 9 cases (6%). Notably, none of the physicians disciplined in Connecticut specialized in pain management. This may be due to differences in descriptions of medical specializations.

Nature of the Cases

The facts of cases ranged widely though were limited by the information provided in reports. Cases of self-use ranged from physicians diverting opioids for their own use with no noted deleterious consequences to physicians who were impaired while practicing — notably, one physician was visibly impaired while working in the operating room. Other cases involved theft of medication and physicians writing prescriptions for themselves in others' names. Several cases of self-use involved associated law enforcement involvement.

Cases characterized as misprescribing often involved physicians prescribing opioids without establishing or maintaining a formal physician-patient relationship. These cases involved prescribing to friends and family, improperly delegating prescribing privileges to office staff, and prescribing outside of a formal office setting. In most, but not all, of these cases, the prescriptions appeared to be for legitimate medical purposes and otherwise followed prescribing guidelines.

Other cases of misprescribing involved failures to properly diagnose and manage established patients taking opioids, often long-term, or failure to heed indicators of abuse. These included failures to conduct drug screens or failure to act quickly on irregular results, prescribing large amounts of opioids and/or in combinations favored for abuse, filling prescriptions early and/or disregarding instances involving multiple providers. A number of these cases were based on the physician's failure to refer patients receiving opioids to appropriate specialists.

In the most egregious cases, identified here as overprescribing, physicians prescribed very high doses of medications to large numbers of patients with cursory or no examination and follow-up and no clear treatment purposes. These cases often involved concomitant insurance fraud or other criminal activity. Though the term is rarely used, the facts of cases, when presented, suggest that the physician was knowingly involved in a criminal enterprise or a "pill mill."

Case Characteristics

The number of disciplinary actions brought to the board did not vary greatly among the years examined. As indicated in **Table 2**, the most commonly cited violation was failure to maintain records (80; 57%) However, there were no cases where failure to maintain records was the sole cause for disciplinary action. In many cases, inadequate recordkeeping served as a proxy for actions not taken by physicians when indicated.

Other common grounds for disciplinary action included failure to treat appropriately, often prescribing increasingly large amounts of opioids to a single patient or not considering patient symptoms or progress (77; 55%) and failure to manage opioid patients appropriately (63; 45%), often involving lack of routine drug screening or lack of consideration about patients' histories of drug misuse. Well over one-third of cases (29; 43%) involved a physician prescribing outside of the physician-patient relationship. A total of 26 (19%) cases involved the prescribing of suboxone/subutex, methadone, or both. Over 10% of cases (15; 11%) involved patient death and 27 cases (19%) involved criminal investigation, charges, and/or prosecution.

How the Cases Came to the Attention of the Medical Licensing Boards

Information on how cases came to the attention of the MLBs was consistently reported in Kentucky's case reports. This information was reported for many but not all cases in Wisconsin and was rarely reported in Connecticut. As **Table 3** indicates, in Wisconsin and Kentucky, 24 cases were identified by a pharmacist or other healthcare provider (17%). An additional 21 cases (19%) were detected by the coroner and other law enforcement officers and 11% (12) of cases were detected by routine monitoring, though Wisconsin did not report identifying cases in this way. A total of 12 cases (16%) in Kentucky and no cases in Wisconsin explicitly referenced the state's PDMP as a prompting event for complaint. Still, PDMPs were often referenced as a tool during case investigations to identify the patients of a physician under investigation for whom chart review was appropriate.

Board Orders or Penalties

In the majority of cases physicians were required to complete continuing education courses (102; 73%) and in many cases, physicians were required to complete professional assessment and remediation plans (33; 23%) and/or be supervised in their practice (32; 23%). A total of 25 physicians (18%) were rep-

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rimanded. These are typically public reprimands and recorded in the physician's record. At times, reprimand was the only action taken by the board; however, reprimands were also combined with other penalties including fines. In Connecticut, fines ranged from $3,000 to $20,000 (mean $5900). In Kentucky, fines ranged from $1,000 to $5,000 (mean $2,600), and the single fine recorded in Wisconsin was $3,000. In some cases, physicians were required to pay federal and civil fines as well.

Across the three study states, 25 (18%) of all disciplinary actions reported resulted in the Board taking the most severe licensing action, either license revocation or surrender. These cases included physicians voluntarily retiring. Further, in 19 (17%) cases, MLBs ordered ex parte emergency suspensions or restrictions. In these cases, the physicians were deemed to be an imminent danger to patients and thus action was taken prior to a formal hearing. The Kentucky MLB did not report ordering any emergency suspensions, though these may have been ordered and recorded elsewhere.

Physicians were also required to reimburse their MLB for the costs to investigate and adjudicate their cases. These costs ranged widely, from $100-$250 in simple cases to more than $10,000 in those that were very complex or contentious.

Between State Comparisons

Although reliable comparisons between states are limited due to the small number of cases reported and the limited information provided about some cases, three statistically significant between-state differences emerged among violations reported. First,

Table 1
Licensee Characteristics

Physician Disciplinary Cases	Connecticut (n=27; 19%)	Kentucky (n=75; 54%)	Wisconsin (n=38; 27%)	Total (n=140)
	n (%)	n (%)	n (%)	n (%)
Recorded Gender				
Female	4(15)	6(8)	8(21)	18(13)
Male	23(85)	69(92)	30(79)	122(87)
Degree				
Doctor of Osteopathic Medicine (DO)	1(4)	5(7)	2(5)	8(6)
Medical Doctor (MD)	26(96)	70(93)	36(95)	132(94)
Practice Area				
Family or internal medicine	18(67)	46(61)	21(55)	85(61)
Emergency	2(7)	2(3)	1(3)	5(4)
Psychiatry	2(7)	2(3)	5(13)	9(6)
Pain management	2(7)	6(8)	2(5)	10(7)
Obstetrics/Gynecology	–	3(4)	1(3)	4(3)
Occupational medicine/physical medicine & rehabilitation	–	3(4)	4(11)	7(5)
Pediatrics	2(7)	1(1)	–	3(2)
Surgery	–	7(9)	–	7(5)
Neurology	–	2(3)	1(3)	3(2)
Other	1[1](4)	3[2](4)	3[3](8)	7(5)

Percentages in columns are percentages of characteristics within the state's total cases.
Percentages may not equal 100% due to rounding.

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compared to the Connecticut and Wisconsin MLB, the Kentucky MLB rarely cited failure to educate patients about opioids as a violation (8.29 (p=.016)) There were also marginally significant differences in Wisconsin's use of failure to diagnose properly (5.77 (p=.056)). Wisconsin cited this much less frequently than Connecticut and Kentucky. On the other hand, Wisconsin cited failure to heed indicators of abuse at double the percentage of Connecticut and Kentucky. 5.85 (p=.054)

Table 2

Physician violations

Physician Disciplinary Cases	Connecticut (n=27; 19%)	Kentucky (n=75; 54%)	Wisconsin (n=38; 27%)	Total (n=140)
	n (%)	n (%)	n (%)	n (%)
Violations				
Failure to diagnose appropriately	8 (34)	34 (45)	9 (24)	51 (36)
Failure to treat appropriately	14 (52)	45 (60)	18 (47)	77 (55)
Failure to educate patient/procure informed consent	4 (15)	1 (1)	5 (13)	10 (14)
Failure to manage opioid patients appropriately	11 (41)	31 (41)	21 (55)	63 (45)
Failure to maintain records	20 (7)	42 (56)	20 (53)	80 (57)
Prescribed outside of physician-patient relationship	6 (22)	17 (23)	6 (16)	29 (43)
Self-use	2 (7)	12 (16)	5 (13)	19 (14)
Failed to heed indicators of patient abuse or patient drug diversion (when explicitly stated in report)	5 (19)	15 (20)	15 (40)	35 (25)
Inappropriate delegation of prescribing privilege	4 (15)	5 (7)	1 (3)	10 (7)
Opioid-related criminal allegations[4]	5 (19)	17 (23)	5[5](13)	27 (19)
Other	17[6] (82)	17[7] (24)	22[8] (58)	58 (41)

Percentages within states are percentages of characteristics within the state's total cases.
Percentages may not equal 100% due to rounding.

Table 3

Cases Involving Suboxone/Subutex and/or Methadone and Patient Mortality

Physician Disciplinary Cases	Connecticut (n=27; 19%)	Kentucky (n=75; 66%)	Wisconsin (n=38; 33%)	Total (n=140)
Suboxone/Subutex and/or Methadone	7 (26)	11 (15)	8 (21)	26 (19)
Cases involving patient mortality	1(4)	10 (13)	4 (11)	15 (11)

Percentages within states are percentages of characteristics within the state's total cases.

Percentages may not equal 100% due to rounding.

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Table 4

Source of Complaints Prompting Physician Disciplinary Action[9]

Physician Disciplinary Cases	Kentucky (n=75; 66%)	Wisconsin (n=38; 33%)	Total (n=113)
	n (%)	n (%)	n (%)
Law enforcement or coroner	18 (24)	3 (8)	21 (19)
Official practice review/audit	12 (16)	–	12 (11)
Non-medical bystander (e.g., family member)	1 (1)	1 (3)	2 (2)
Patient	3 (4)	1 (3)	4 (4)
Another healthcare provider or staff	10 (13)	2 (5)	12 (11)
Pharmacist	10 (13)	2 (5)	12 (11)
Insurer or payor (e.g., Bureau of Worker's Compensation)	1 (<1)	1 (3)	2 (2)
Self-report	1 (<1)	2 (5)	3 (3)
Complaint — anonymous or not specified	13 (17)	6 (16)	19 (17)
Other	3[9]	1 (3)[10]	4 (35)
Not reported	2	19 (50)	21 (19)

Percentages in columns are percentages of characteristics within the state's total cases.
Percentages may not equal 100% due to rounding.

Table 5

Disciplinary Orders

Physician Disciplinary Cases	Connecticut (n=27; 19%)	Kentucky (n=75; 54%)	Wisconsin (n=38; 27%)	Total (n=140)
	n (%)	n (%)	n (%)	
Orders				
License revocation or surrender/retirement	4 (14)	4 (5)	17 (45)	25 (18)
License suspension	6 (22)	–	16 (42)	22 (16)
License restriction	8 (30) [11]	11[12] (15)	25[11] (66)	44 (31)
Continuing medical education	14 (52)	14 (19)	30 (79)	102 (73)
Professional assessment and remediation program	–	1(1)	32(84)	33 (23)
Physician supervision	6 (22)	13 (17)	13(34)	32 (23)
Substance use disorder treatment plan and abstinence	3 (11)	11(15)	11(29)	15 (11)
Monetary fine	15(55)	5(7)	1(3)	21 (15)
Reprimand	16 (59)	19 (25)	–	25 (18)
Ex parte emergency license suspensions or restrictions	1 (3)	–	18 (47)	19 (17)

Percentages in columns are percentages of characteristics within the state's total cases.
Percentages may not equal 100% due to rounding.

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Table Endnotes

1. Pathology
2. Cardiology; radiology; urology
3. Three anesthesiologists
4. Criminal allegations are indicated by criminal investigation/charges with probable cause. These cases include both criminal acts related to opioid diversion and to self-use.
5. One licensee was convicted of a crime in another state
6. Didn't clearly discharge patient/dismissed/abandoned patient; Failed to document APRN supervision plan; Prescribed opioids without Controlled Substance Registration; Prescribed injectable medications to office staff for administration to patients; Physician impaired by illness; Wrote prescriptions for a colleague whose Controlled Substance Registration was revoked; Wrote a prescription in one name for another person; Failed to maintain control of prescription pad; Stored patients' medications; Didn't clearly discharge patient/dismissed or abandoned patient; Physician "stocking up" on medications before Controlled Substance Registration lapsed.
7. Failure to supervise staff; Prescription pad displayed the address of an office that was closed; Practicing beyond training; Gave small amount of licensee's own medication and marijuana to friend; Stole/misappropriated medication; Alleged exchange of treatment for a car discount; Sexual misconduct/inappropriate relationship with patient; Failure to supervise staff; Sexual misconduct/inappropriate relationship with patient; Prescribed for self with colleague's Controlled Substance Registration unbeknownst to colleague; Physically impaired; Stole/misappropriated medication for self-use; Staff member who was terminated for altering a prescription for self-use was rehired; Noncompliance with previous order resulting in license suspension and subsequent practice without a license; Unnecessary surgery for personal financial gain.
8. Treatment outside of the office**;** Prescribed controlled substances without a medical license; HIPAA violation; Improper drug disposal; Prescribed to persons known to have opioid use disorders; Abuse of authority to avoid concerns about physician's prescribing; Practicing beyond training; Abuse of authority when concerns were expressed about physician's prescribing practices; Treatment outside of office; Treatment outside of office; Illegal billing; Sexual misconduct/inappropriate relationship with patient; Didn't clearly discharge patient; Board found not in violation.
9. The source of complaints was not reported in Connecticut case records.
10. Complaint prompted during supervision from a previous order; Complaint prompted by an investigation related to patient's other prescriber; Complaint prompted by a medical emergency at the licensee's home
11. Complaint by group home staff
12. Records for five licensees indicated that their restrictions were permanent.
13. Records for two licensees indicated that their restrictions were permanent.

Discussion

Cases rarely involved a single incident, suggesting that MLBs adhere to the suggestion by Dineen et al. that physician discipline is only appropriate when infractions are repeated or ongoing.[37] This may be reassuring to physicians who fear repercussions because of their treatment of a single case or worse, a single decision they have made.[38] Many cases were based on actions that physicians did not take rather than their prescribing decisions. These included cases where a formal physician-patient relationship was not established, diagnosis was cursory, case notes were absent or inadequate, and importantly, the physician failed to monitor patients receiving longer-term opioid treatment. Some of these infractions are inconsistent with state law or MLB prescribing recommendations, suggesting that enhanced regulations, while reflecting best practices, may prompt increased disciplinary actions. It is important to note, however, that the physicians in these cases often overlooked serious signs of drug diversion and addiction or prescribed amounts of opioids or combinations of medications that could jeopardize patients.

A significant portion of cases involved methadone and suboxone. Although patients being treated for opioid use disorders may be among the most challenging, enhanced regulations related to prescribing these drugs also play a role in physician's infractions. For example, several physicians exceeded the allowed number of patients receiving suboxone and at least one violated regulations regarding storage and dispensing. Today, the cap on numbers of patients a physician can see for methadone and suboxone treatment has been lifted.

MLB orders relied heavily on continuing medical education courses (CMEs). The effectiveness of these on modifying physician behavior does not appear to have been examined. Still, it is questionable that 15–20 hours of continuing education will substantially alter a physician's practices in these serious cases. In Kentucky, required CMEs are often coupled with physician evaluation and individualized practice plans. This may be a more effective approach.

Although physicians are not often required to pay fines, one element of disciplinary actions that is often overlooked is that disciplined physicians are often required to reimburse the costs of adjudication, which can be substantial. Many cases also require physicians to be supervised for as long as one year, often at the physician's expense. Further, cases may extend for more than two years, and physicians may be required to go before the MLB several times before their license is reinstated in full. The cost of adjudication and supervision and the time and effort taken to regain full

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practice privileges may increase physicians' concerns about being brought before their MLBs and in some cases may motivate more careful diagnosis, treatment, and record keeping.

Conclusions

It is critical that physicians keep careful records, consistently conduct routine screenings, and ensure that a documented physician-patient relationship is established for each patient receiving opioids. A closer examination of MLB cases related to medications used to treat substance use disorders is also indicated. Law and policy makers should ensure that distrust of medications to treat opioid use disorder is not manifested in regulations. More consistent physician disciplinary case reporting across US states is needed to identify and to address trends in cases.

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