# Regulatory Organizations for Physicians' Status and Administrative Sanctions on Physicians

## —Examining the Framework of Government Administrative Systems for Physicians in Japan Based on a Questionnaire Survey Conducted on 13 National Medical Associations—

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## Abstract

Society bestows professional privilege on physicians. At the same time, it expects physicians to strive constantly to improve their ethics and quality in medical expertise. In every nation, some level of government is responsible for certifying or licensing physicians and imposes strict management, including revoking licenses from inappropriate physicians or providing severe sanctions for misconduct or conduct unbecoming of a physician. In reality, however, it is difficult to reduce the number of inappropriate or indiscreet physicians, and each nation faces its own challenges. We conducted a questionnaire survey of 13 national medical associations, including some major Western countries, regarding the licensing of physicians, the organizations managing their medical practice status, and the data and grounds for administrative sanctioning of physicians. We then examined the circumstances in Japan based on the survey results and pointed out the domestic issues.


**Key words** Physician's license and management organization, Administrative sanctions, Global situation

## Introduction

Physicians are granted various privileges because medical practice directly impacts the life of patients. At the same time, great emphasis has been placed on physician quality improvement and the importance of ethical discipline. Professional associations have rules and measures for these purposes, and many rules and guidelines are provided by administrative authorities. Although an individual physician's ethical awareness and self-discipline is essential, sometimes a human can engage in misconduct or inappropriate conduct because of laziness, spontaneous impulse, or casual carelessness. Therefore, regulation by professional organizations such as medical associations, academic societies, and administrative authorities is important. For years, we have examined the measures to be taken to govern physicians by focusing on the activities of the Japan Medical Association (JMA) Committee for Ethics and Quality Improvement of Members, with a particular emphasis on continuing ethical education as well as government administrative frameworks for managing physicians' medical practice status. In our activities, we have consistently pointed out that the government management of physicians in Japan has many problems compared to other nations.

Recently, we conducted a questionnaire survey of 13 national medical associations that belong to the World Medical Association (WMA) including some major Western countries, through the JMA International Affairs Division. The survey con-

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**Table 1 Organizations for regulating sanctions of inappropriate physicians, physicians with misconduct, and license renewal by countries**

| Countries | Agency for monitoring physicians | Punishment body/Final decision | Renewal program |
|---|---|---|---|
| 1. Brazil | Federal Council on Medicine | Regional Council on Medicine | – |
| 2. Canada | Provincial College of Physicians & Surgeons | Provincial College of Physicians & Surgeons | + |
| 3. Denmark | Danish National Board of Health | Danish National Board of Health | – |
| 4. France | Conseil National de l'Ordre des Medecins | Regional Medical Council Disciplinary Chamber/French Council Disciplinary Chamber | – |
| 5. Germany | State Ministry of Health | ① Landesärtztekammer (State Medical Association)<br>② Disziplinarverfahren (Professional Court Proceedings)<br>③ Criminal Proceedings | – |
| 6. Israel | Ministry of Health | Ministry of Health | – |
| 7. Korea | Ministry of Health and Welfare | Ministry of Health and Welfare | – |
| 8. Singapore | Medical Council | Complaints Committee in MC<br>Disciplinary Tribunal in MC | + |
| 9. South Africa | Health Professions Council | Medical and Dental Board of Health Professions Council/ Appeals Committee of the Council | + |
| 10. Taiwan | Ministry of Health | Committee on the Discipline of Physicians in the Ministry of Health | + |
| 11. Thailand | Medical Council | Subcommittee of MC/Board of the Medical Council | – |
| 12. UK | General Medical Council (GMC) | Medical Practitioners Tribunal Service | + |
| 13. USA | State Medical Board | State Medical Board | + |
| 14. Japan | Ministry of Health, Labor and Welfare | Medical Ethics Council | – |

cerned the following 5 topics: (1) organizations in charge of physician's license management; (2) whether the license is permanent (or needs to be renewed); (3) organizations in charge of sanctioning physicians showing misconduct or inappropriate physicians; (4) the number of physicians sanctioned and the details of their sanctions; and (5) the main reasons for sanction. We also reevaluated the issues of the management system in Japan according to the survey results.

## Organizations in charge of managing physicians' licenses and medical practice status (Table 1)

Due to the social importance of the medical profession, nations across the world have currently adopted a national licensing system for physicians, and many countries have a national examination or an equivalent assessment that must be passed to acquire a physician's license. Therefore, we can say that physicians' licenses are strictly managed on the national government's responsibility. The exact organization in charge of managing the license varies among countries; it may be a government ministry/agency or statutory body. Overall, there are 3 types of regulatory organizations: (1) a government ministry or agency, as seen in Japan, Korea, Taiwan, Thailand, Singapore, Israel, and Brazil; (2) a public institution independent of but designated by government ministries/agencies, as seen in the United Kingdom, some states in the US, and South Africa; and (3) a medical association or other physician organization with com-

pulsory membership, as seen in France, Germany, and Canada. Each type has its own advantages and disadvantages, and we cannot hastily conclude which type is the best. Type 1 appears to be common in countries with a relatively small population size, with the exception of Japan. The typical examples of Type 2 are the state licensing boards in the US and the General Medical Council (GMC) of the UK. In Type 2, the attitudes of non-physicians, namely the general public and patients, are valued in monitoring physician conduct. The GMC in particular deals with a wide range of subjects in medicine and medical care, such as the health care system and medical education. Type 3 applies only to the countries that have medical associations or physician organizations in which membership is compulsory for all physicians. The purpose of establishing such organizations is not only to guarantee the status of physicians, but to nurture physicians' ethical self-regulation and discipline. They may look more like an organization for managing physician status. In these countries, monitoring and cleaning among physicians are expected to contribute to physicians' ethics and to quality improvement.

### Renewal systems of physicians' licenses (**Table 1**)

About half of the surveyed countries, including the US and Canada, have adopted a renewal system for physicians' licenses; however, there is no similar system in nations such as Germany, France and Japan. The UK adopted a renewal system very recently. Renewing physicians are obligated to complete certain training within the renewal period, which is expected to improve their clinical skills. However, such renewal procedures require efforts from physicians, and some question their efficacy compared to the amount of effort. Many countries refer to this as one reason for their reluctance to adopt a renewal system.

### Organizations for regulating sanctions of inappropriate physicians and physicians with misconduct (**Table 1**)

Each nation has strict sanctions for inappropriate physicians and physicians with misconduct. The details of sanctions are typically decided by the aforementioned regulatory organization in each nation; however, the actual procedure can vary among nations. Many countries adopt a system in which an initial sanction is followed by review with a possibility of appeal. Some countries have more complicated systems. In Germany, for example, only the state government has the authority to grant, suspend, and revoke a physician's license in principle. But in exceptional cases, a criminal court can also suspend or revoke a license. Furthermore, Germany has a compulsory medical association for physicians, *Landesärztzekammer*, and its internal board has the final authority to punish the members. The review of severe sanctions, however, is in principle entrusted to a special occupational court, *Berufsgerichtliche Verfahren*, consisting of physicians and a judge. The German system is quite complicated because insurance doctors (doctors working under the health insurance program) are also subject to their sanction. In the UK, an independent adjudication organization called the Medical Practitioners Tribunal Service was recently launched to take charge of administrative sanctioning of physicians.

### Number of sanctioned physicians and the details of sanctions in a recent year (**Table 2**)

Each nation presumably has a very strict attitude when dealing with administrative sanctioning of physicians. Unfortunately, some countries do not have statistics on the total number of sanctioned physicians, so we were only able to obtain answers from 21 of 23 respondents. One clearly noticeable statistic is the large number of sanctioned physicians in the US. Of course, the number varies among the states, and some states have figures much lower than others. Nevertheless, the number observed in the US as a whole is exceptionally large compared to other countries. In that respect, the proportion of the sanctioned physicians to the total number of licensed physicians is much lower in Japan and Thailand. We cannot easily conclude whether this is because the regulatory system is too soft or because few physicians commit misconduct in those countries.

### Grounds for physician sanction (**Table 3**)

The top 4 grounds for sanctioning physicians in Japan are: (1) committing indecent acts; (2) causing death or injury through professional negligence (medical errors/negligence); (3) submitting false claims for medical fee payments;

**Table 2 Details of sanctioned physicians and the details of sanctions**

| Countries | Year | Total No. of physicians | Details of sanction | | | | | Restriction/ Total physicians |
|---|---|---|---|---|---|---|---|---|
| | | | Restriction of license | Revocation Suspension | Reprimand | Fine | Others | |
| 1. Brazil | 2012 | 377,561 | No data | | | | | |
| 2. Canada* | 2000-2009 | 69,700 active (2010) | Total for 10 years from 2000<br>382 { Revocation 89<br>Suspension 293 | | 273 | 416 | 446 | 382/69,700/ 10 years 0.05% |
| 3. Denmark | 2012 | 26,238 | 61 | Rare | | | | 61/26,238 0.2% |
| 4. France | 2012 | 271,970 | 154 | 24<br>130 | 163 | 112 | | 154/271,970 0.05% |
| 5. Germany | 2011 | 449,409 | No data | | | | | |
| 6. Israel | 2011 | 34,657<br>23,500 active | No data | | | | | |
| 7. Korea | 2012 | 84,544 | 355 | 13<br>342 | 76 | | | 355/84,544 0.4% |
| 8. Singapore | 2011 | 10,057 | 15 | 0<br>15 | 23 | 20 | | 15/10,057 0.1% |
| 9. South Africa | 2012 | 39,912 | 18 | 1<br>17 | 12 | 67 | | 18/39,912 0.04% |
| 10. Taiwan | 2012 | 42,310 active | No data | | | | | |
| 11. Thailand | 2011 | 43,408 | 2 | 1<br>1 | 17 | | | 2/43,408 0.004% |
| 12. UK | 2011 | 245,918 | 158 | 65<br>93 | 16 | | 24 | 158/245,918 0.06% |
| 13. USA** | 2011 | 834,769 active | 3,228 | 1,905<br>1,323 | | | 1,768 | 3,228/834,769 0.3% |
| 14. Japan | 2012 | 295,049 | 52 | 8<br>44 | 6 | | | 52/295,049 0.01% |

The figures listed in this table except for Canada and the US are basically copied from the answer sheets to the questionnaire collected from each NMA.
*The data for Canada except for the total number of physicians are cited from "The characteristics of physicians disciplined by professional colleges in Canada" by Asim Alam, et al., Open Medicine Vol.5, No.4, 2011.
**Based on the figures shown in "the Federation of State Medical Boards, Summary of 2011 Board Actions", the data for the US are arranged by the editorial board of the JMA Journal to fit this table.

and (4) causing death or injury through personal negligence (traffic accidents and driving violations). In this survey, we asked the respondents to list 5 main grounds. The responses suggest that the grounds for sanction vary considerably among countries, which may reflect the social situations or culture of each country. Nevertheless, we noticed some useful insights.

The first notable finding is that pecuniary reasons (e.g., false claims of medical fee payments, tax evasion, fraud, forgery of documents such as medical certificates, and bribery) are common. There are no nationwide statistics on the grounds for physician sanction in the US. In some states, however, tax law violations and insurance reimbursement fraud are prominent. This suggests that humans are vulnerable to pecuniary temptation, and that physicians are no exception. Physicians often do not consider the forgery of documents, whether intentional or not, to be a crime. Therefore, it is extremely difficult to eradicate this type of misconduct. The number of physicians sanctioned for submitting false claims of medical fee payments has remained relatively stable over time in Japan as well. False claims appear to be a major problem in countries that have an extensive nationwide public health insurance system, and thus poses a challenge for those countries. However, some countries with nationwide public insurance sys-

**Table 3 Grounds for physician sanction**

| Countries | Description |
|---|---|
| 1. Brazil | No data |
| 2. Canada | ① Sexual misconduct<br>② Failure to meet a standard of care<br>③ Unprofessional conduct<br>④ Fraudulent behavior<br>⑤ Inappropriate prescribing |
| 3. Denmark | ① Failure to comply with regulations of the National Board of Health on medication<br>② Failure to comply with other regulation<br>③ Failure to comply with regulations on medical records<br>④ Having received three reprimands on malpractice from an independent board on complaints will result in the publication of the name of the doctor on website. |
| 4. France | ① Confraternity<br>② Conscientious care<br>③ Certificates<br>④ Duties or behaviours towards patients<br>⑤ Advertising |
| 5. Germany | No data |
| 6. Israel | No data |
| 7. Korea | ① False claims for medical fee payment<br>② Practicing under an employer who is unqualified to run a medical institution (by the Medical Law)<br>③ Advertising without going through a due process of medical advertisement review or making a false or exaggerating advertisement<br>④ Letting non-medical professionals do medical practices or do medical practices beyond the legally admitted purview<br>⑤ Issuing prescriptions, medical certificates, death certificates, other certificate without seeing patients in person |
| 8. Singapore | No data |
| 9. South Africa | ① Fraudulent claims to medical funders 44%<br>② Medical negligence 30%<br>③ Practicing/employing unregistered persons 15%<br>④ Sexual misconduct 6%<br>⑤ Breach of confidentiality 5% |
| 10. Taiwan | ① False claims for medical fee<br>② Exaggerated advertisement<br>③ False medical certificate |
| 11. Thailand | ① Practice with poor medical standard<br>② Indecency<br>③ False claim for medical fee payment<br>④ Lack of patient safety<br>⑤ Issuing false medical certificates |
| 12. UK | ① Clinical care<br>② Relationships with patients (respect)<br>③ Relationships with patients (communication)<br>④ Probity—criminal conviction<br>⑤ Probity—writing reports/documents |
| 13. USA | No data |
| 14. Japan | ① Indecency<br>② Medical errors/negligence<br>③ False claims for medical fee payment<br>④ Professional negligence causing injury and death |

tems have apparently low rates of false claims; those countries may have circumstances that make it difficult to make a false claim.

In recent years, serious malpractice associated with medical accidents and substandard and incompetent skills are becoming increasingly common reasons for sanction in each nation. Institutional improvement regimes are adopted to address the problem of medical accidents, and continuing education for physicians is being offered more often.

Although it is not directly tied to medical care, personal conduct that relates to the character and dignity of a physician is also subject to sanction in many countries. In Japan, indecency has been the most common reason for sanction for the last 10 years. Indecent acts forced on patients are subject to severe sanction, including revocation of the physician's license. However, more than half of indecent acts are not associated with medical care (prostitution with a minor, peeping photos/videos on public streets, etc.). Such acts are sanctioned by fines or other methods under criminal law before a physician's license or medical practice is restricted. In some cases, the question has been raised whether such double sanction is necessary. The UK, Canada, and Thailand listed indecent acts as one of the top reasons for sanction, but there appears to be a gap in the details of sanctioning across countries.

Other grounds for punishment listed in the survey include medical practice by non-licensed persons, exaggerated/misleading advertising, and violations in handling narcotics and psychotropic drugs. These problems seem to be common among the surveyed countries. France is characteristic in that their top reasons for sanction included breaches of professional duty to patients and the interference in professional doctor-to-doctor relationships or family problems. Japan is unique in that many kinds of traffic violations—driving under the influence, driving accidents, or causing death or injury through negligence in traffic accidents—can become grounds for sanction, even though they are not directly related to medicine.

## Discussion

As medicine advances and becomes more accessible to the general public, people's expectations toward medical care is elevated, and the professional ethics of physicians has become increasingly important. Ethics primarily depend on the awareness of each individual physician. Nevertheless, efforts by professional organizations such as medical associations, academic societies, and administrative authorities are also needed. In this paper, we investigated the conditions of 13 surveyed countries with regard to administrative issues, management systems of physicians' medical practice status, and administrative sanctioning of inappropriate physicians and physicians with misconduct or conduct unbecoming of a physician. In light of the survey results, we believe that Japan has the following problems.

First, there are close to 300,000 physicians in Japan, and their licenses and medical practice status are all managed by one bureau in the Ministry of Health, Labour and Welfare. This is quite exceptional in comparison to the other nations' systems of other countries, and the current system needs a reform as we have been pointing out. Under the Medical Practitioners' Act, the Minister of Health, Labour and Welfare is supposed to sanction unfit physicians upon hearing the opinion of the Medical Ethics Council. Such physicians include (1) physicians incapable of performing his/her professional duty due to mental/physical disability; (2) physicians who are addicted to narcotics, marijuana, opium, or other illegal substances; (3) physicians who received civil or criminal punishment that is more serious than a fine; and (4) physicians who have committed a crime or misconduct in his/her medical practice or who have committed conduct unbecoming of a physician. In reality, however, a sanction on anyone who receives punishment more serious than a fine (item 3) is entrusted to the Medical Ethics Council, and is determined solely based on precedent. The Council has a right to conduct its own investigation, but it is rarely exercised in case review; the Council is merely reviewing a case in which facts have been already established and a court ruling has already been made. There is a channel to accept complaints and claims from the public, patients, and medical/healthcare personnel in many countries, and the referred cases are subject to sanction. Such channels have been established in each prefecture in Japan. However, their function has yet to reach their full potential, and there is no particular flow of processing

from accepting a relevant case for review to assessing a sanction.

In addition, the number of sanctioned physicians in Japan is comparatively small globally, and the public in Japan may not regard the problem of inappropriate physicians or physicians' misconduct as a serious issue. Nevertheless, even a small number of offenders can lead to damage people's trust in all physicians. Although the number of sanctioned physicians has remained relatively unchanged for the last 10 years, the regulatory system of physicians' medical practice status requires improvement.

At any rate, as we have discussed, the root of the problem in this nation lies in the fact that a small number of government bureaucrats in one ministry manage the sanctioning of all physicians nationwide. One possibility for reform would be to transfer the authority to license and manage physicians to municipal governments. Alternatively, a medical association with compulsory membership for all physicians can be established, as in France and Germany. Examining these possible measures is an essential challenge in order to improve the physician management system in Japan.

## Conclusion

We conducted a questionnaire survey of the national medical associations of 13 countries, including several major Western countries, on the regulation of physicians' licenses, management of physicians' medical practice status, and administrative sanctioning of physicians, in order to examine the problems in Japan. At present, a large number of physicians in Japan are managed by a small number of bureaucrats in a ministry and agency. We conclude that the current system is inadequate, and that system reform is required to improve care quality and professional ethics among physicians.

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