Original Research Article

Sex, Drugs, and Continuing Education: Analysis of Professional Misconduct by Healthcare Licensees in Michigan (2011-2023)

Nicole Alvarez, BS; Tyler S. Gibb, JD, PhD

ABSTRACT:

Background: While high-profile cases have drawn attention to egregious violations committed by healthcare providers, less is known about the broader patterns of misconduct across all healthcare professions.

Methods: This study examines misconduct trends across 27 healthcare professions in Michigan between 2011 and 2023, utilizing data from the Department of Licensing and Regulatory Affairs (LARA). The project converted publicly available LARA disciplinary reports into an analyzable digital database, facilitating a comprehensive understanding of healthcare provider misconduct.

Results: Findings include an 83.2% increase in complaints between 2011 and 2023, contrasted with a 3.6% decline in total sanctions over the same period. Negligence was the most frequently observed misconduct across all healthcare boards, while certain professions exhibited disproportionately high rates of misconduct. Sanctions varied widely, with fines being the most common and permanent license revocations being exceedingly rare.

Conclusions: The study highlights systemic challenges in oversight, including inconsistent reporting mechanisms, finite regulatory resources, and gaps in accountability. By revealing these limitations, the data underscores the need for process and policy reforms to improve transparency, standardize reporting, enhance regulatory capacity, and prioritize preventive intervention.

This study identifies professional misconduct trends amongst Michigan healthcare providers (2011–2023), including high rates of sexual misconduct and violations of continuing education requirements in some professions. Fragmented and inconsistent reporting hinders effective oversight, undermining patient safety and public trust in the healthcare system.

Introduction

Medicine is inherently a moral enterprise, grounded in a “covenant of trust” between patient and healer—a principle that has long underscored the ethical foundation of clinical care[1]. This trust relies upon mutual respect, understanding, and an implicit agreement between the patient and the healthcare provider. Recent high-profile cases illustrate how profoundly this trust can be breached, including that of Robert Anderson[2], a former University of Michigan physician who abused hundreds of patients over decades, and Larry Nassar[3], a USA Gymnastics doctor convicted of sexually abusing young athletes.

These troubling cases have drawn national attention, but the broader, more pervasive issue of provider misconduct continues outside of headlines, exposing systemic failures that erode public trust across all healthcare professions. Less publicized cases of serious misconduct, such as abuse of vulnerable patients, financial exploitation, sexual assault, and prescription drug misappropriation, are equally problematic. Misconduct occurs in all health professions, highlighting the urgent need to strengthen regulatory frameworks and accountability measures.

These cases prompt a simple question: How widespread is professional misconduct across

healthcare, and what measures, if any, are in place to address it? Disciplinary Action Reports (DARs), published by Michigan's Department of Licensing and Regulatory Affairs (LARA), document disciplinary actions across all regulated healthcare providers in Michigan.

Michigan is a useful case study for several reasons. First, Michigan is the 10th most populous state in the US as of 2024, making the population and diversity of healthcare providers like many other states. Additionally, Michigan statute requires that disciplinary actions taken by any healthcare board be publicly disclosed, which creates the opportunity for cross-professional analysis. During the study period, both Republican and Democratic leaders held control of the legislature and governorship, providing a politically balanced context in which both parties have influenced the regulatory landscape, making policy recommendations more broadly applicable.

This study systematically examines patterns of healthcare provider misconduct across 27 regulatory boards in Michigan, identifying regulatory gaps and proposing evidence-based policy reforms to enhance oversight and accountability.

Methods

Data Source

The primary dataset for this study was derived from DARs published by Michigan LARA between FY2011 and FY2023[4]. As required by Michigan statute, these publicly available reports provide information about healthcare professionals subject to LARA regulatory oversight and who have had adverse actions taken against their license in Michigan. Each DAR includes the name, license number, profession, and location of the disciplined healthcare provider, the specific misconduct committed (ranging from failure to meet continuing education requirements to serious professional and criminal misconduct), and the disciplinary actions taken by LARA.

Some information necessary for robust analysis, such as overall licensees regulated by each Board and data describing complaints made to each Board, is not available in LARA's weekly DARs. We incorporated information from "Michigan Health Professional Disciplinary Reform Reports"[5] published annually by LARA, which provides the annual number of complaints filed with each Board. The overall number of licensed professionals under each Board, necessary for workforce proportion calculations, is available in the "LARA Annual Report of Board Activities."[6] Despite extensive efforts—including outreach to LARA administrators and FOIA requests—data from FY2012 remains unavailable, without clear reasoning as to why. While this introduces some limitations, interpolation techniques and cross-validation with comparable state datasets enhance the study's reliability.

Handling Missing Data

Due to gaps in the available data, particularly for FY2012, we interpolated missing values using quadratic and linear regression models, cross-referencing with similar data from neighboring states to observe alignment with other reported trends. This interpolation provided reliable estimates that matched the overall patterns observed in the Michigan dataset. However, attempts to interpolate complaint data for specific years, such as FY2017, were less successful due to the significant variability in complaint data from year to year. Specifically, in FY2017, a state-level database migration in LARA's licensing system resulted in incomplete data for nursing, limiting the report to actions from October 1, 2016, to July 31, 2017. Despite these challenges, the FY2017 data were included in the analysis to maintain the study's chronological continuity.

Data Extraction and Cleaning

We converted DARs into an analyzable format using Tabula, an open-source PDF extraction tool, to render the data easily analyzable.[7] The raw data was imported into Microsoft Excel for manual cleaning. During data cleaning, a single researcher corrected input errors, standardized terminology ad hoc, and aligned each disciplinary action with its corresponding provider and specific misconduct category. Inconsistent terminology (eg, variations such as "criminal sexual conduct" vs. "sexual criminal conduct") and typographical errors presented challenges, necessitating meticulous data validation and cross-checking for accuracy.

Our dataset included DARs containing a final sanction and misconduct category during FY2011-FY2023. Of note, the date associated with each DAR is the date that the final action against the licensee was taken for that specific instance of misconduct. Of the 15,902 disciplinary orders examined, 12,072 were included in the analysis. Orders lacking a documented form of misconduct or a final sanction were excluded. For instance, orders

 2025 Federation of State Medical Boards

published after a license was reinstated were not included in the dataset, as they were duplicates of previous entries. Similarly, orders involving Summary Suspensions were omitted, as these do not represent final Board sanctions captured elsewhere in the dataset.

Binary Classification of Misconduct

We established a binary classification system to categorize each instance of reported misconduct, mirroring statutory categories and language. Each disciplinary action and its statutory basis were coded as present (1) or absent (0), thus providing a structured dataset for comparative analysis.

Results

Complaints and Sanctions

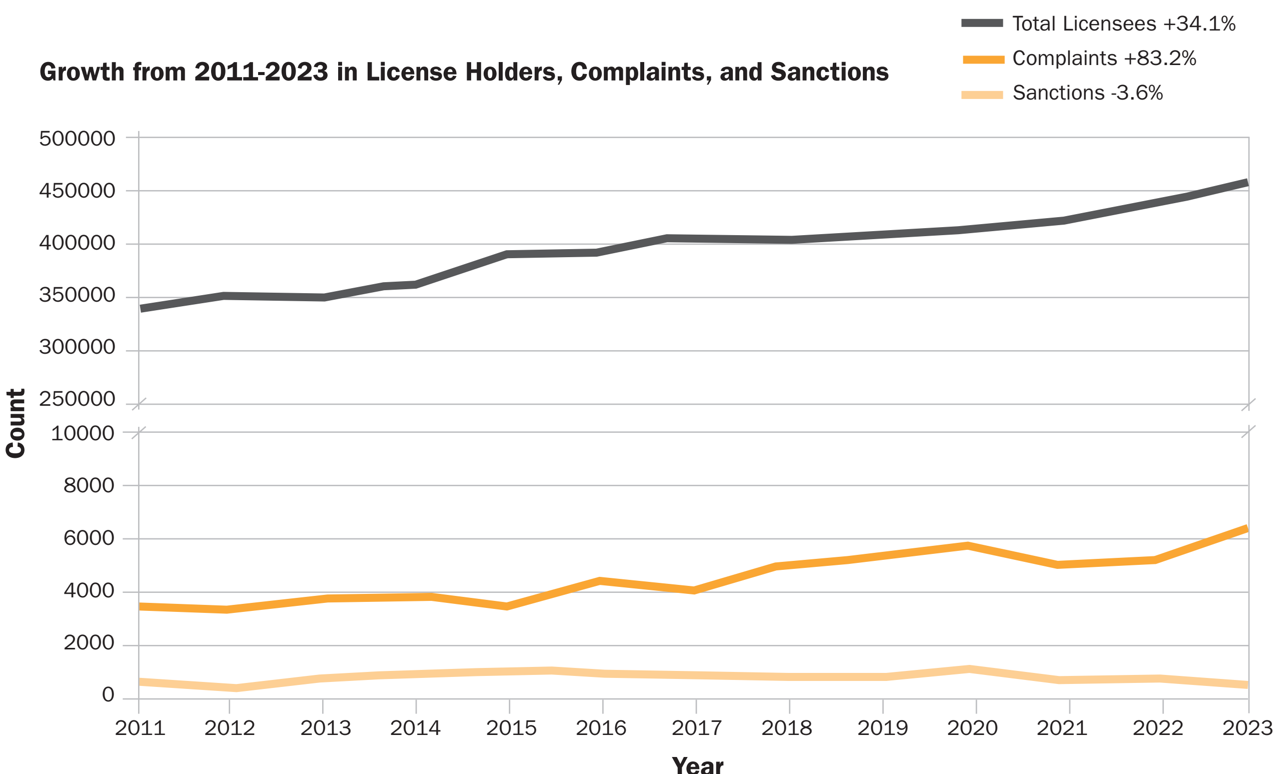
Between FY2011 and FY2023, 57,244 complaints were filed against healthcare providers in Michigan's 27 regulated healthcare professions. Of these, 12,258 (21.4%) resulted in formal sanctions. The distribution of complaints varied significantly across professions and at the average number of complaints per 1,000 licensees (Table 1), with some professions receiving higher complaint volumes per capita.

Table 1
Avg Number of Complaints per 1000 Licensees by Healthcare Profession, FY2011–FY2023

Profession	Avg Number of Complaints per 1000 Licensees
Nursing	8.11
MDs	31.4
DOs	27.9
Social Work	8.4
Dentists	14.7
Pharmacy	13.3
Counseling	8.2
Massage Therapy	5.8
Physical Therapy	2.6
Occupational Therapy	2.1

Total complaints rose by 83.2% (3,478 in FY2011 to 6,371 in FY2023). Despite this substantial increase in complaints and a 34.1% increase in licensed providers (338,934 to 454,564) over the same period, the total sanctions issued by LARA decreased by 3.6% (746 to 720) (Figure 1).

Figure 1
Percentages of Licensees, Complaints, and Sanctions FY2011 - FY2023



Among the five largest healthcare professions (Nursing, Pharmacy, Medicine, Social Work, and Dentistry), the percentage of filed complaints resulting in sanctions varied considerably (Figure 2). The Board of Social Work demonstrated the most significant variability, ranging from 9.5% in FY2023 to a peak of 59.2% in FY2014, with an average of 34.7% (± 14.9%). In contrast, the Board of Medicine demonstrated relatively consistent sanctioning rates, with an average of 11.3% (± 3.3%) and a range of 7.0% to 19.6%.

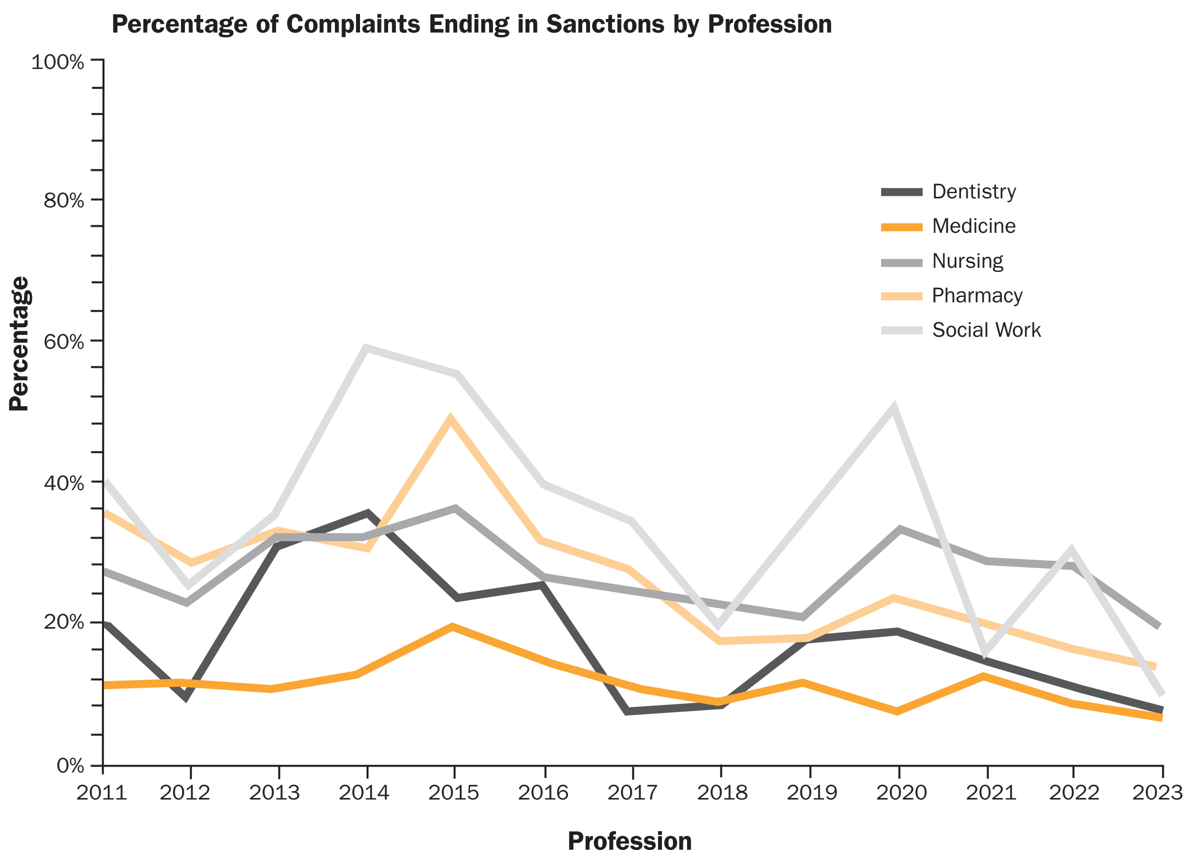
Sanction Utilization

Fines were the most frequently levied sanction of all final orders (75.0%), followed by probation (51.3%). In contrast, permanent revocation was the least utilized sanction, occurring in only 12 cases during the 13-year study period. Interestingly, 83.3% (10/12) involved criminal sexual conduct. To further analyze sanctions related to sex, we combined "criminal sexual conduct" (Appendix B- 16221(b)(vii) and 16221(b)(xiii)) and "sexual misconduct" (Appendix B- 16221(b)(xv), 16221(e)(vi), and 16221(e)(vii)) into a broader category "sex-related misbehavior." Of those sanctioned for sex-related misbehavior, 4.6% (11/237) ended with permanent revocation of the practitioner's license to practice healthcare, and 23.2% (55/237) received a non-permanent revocation (three to five years), allowing them to reapply for their license after the time had elapsed. Others received punishments such as fines, probation, or license suspension.

Misconduct by Profession

An examination of misconduct across professions showed that nurses and physicians (MDs and DOs) represented the highest number of sanctioned individuals, possibly reflecting their more prominent workforce presence. However, data normalized to the number of professionals reveal that some professions, such as Podiatrists, Nursing Home Administrators (NHAs), and Chiropractors, have disproportionately high misconduct rates. For instance, Podiatrists, who constitute 0.22% of all healthcare professionals, account for 0.51% of misconduct cases, indicating that misconduct among Podiatrists occurs at approximately twice the expected rate based on workforce representation.

Figure 2
Year-over-Year Trends in Percentage of Complaints Ending in Sanctions



2025 Federation of State Medical Boards

Trends in Misconduct Types

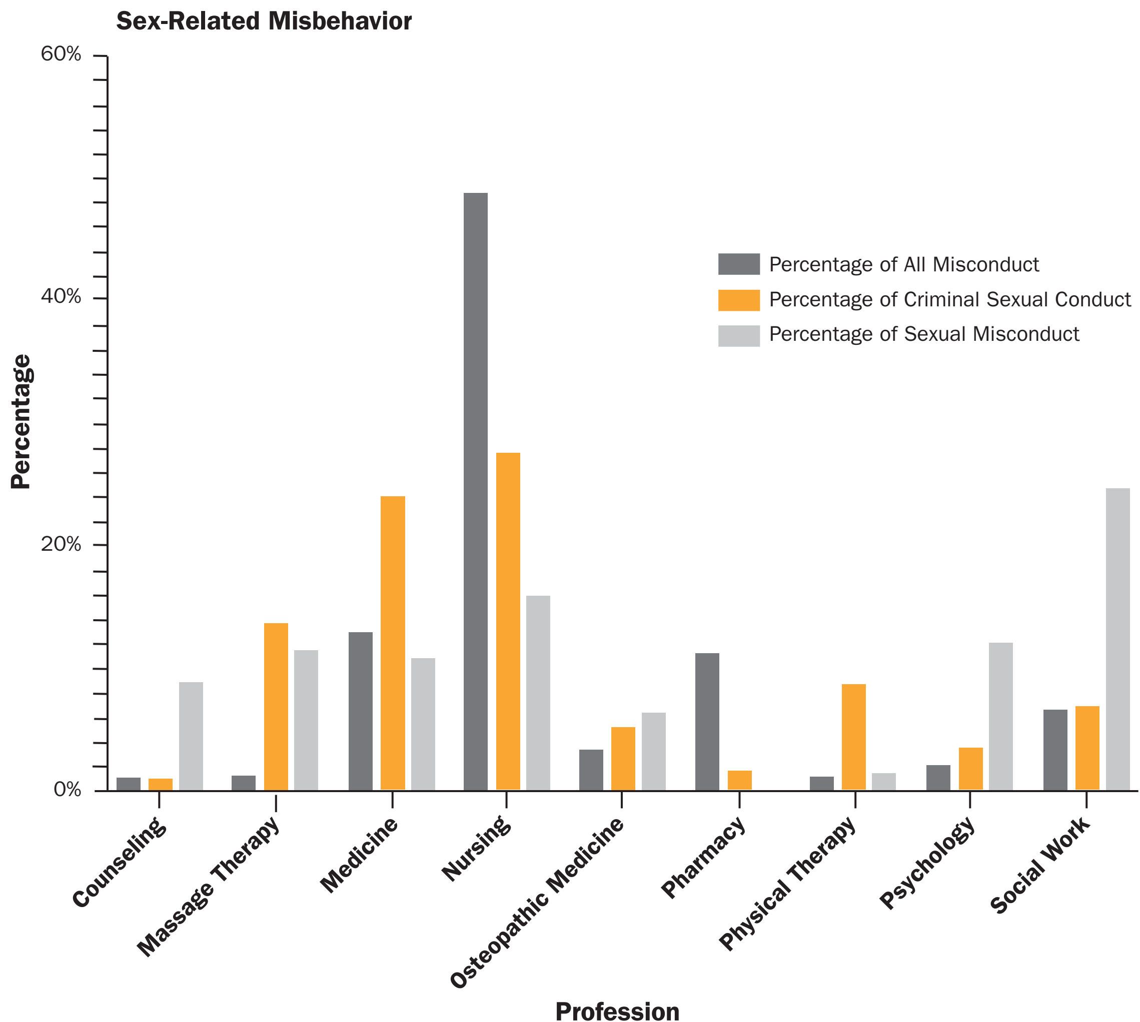
Negligence (see Appendix B- 16221(a)) was the most cited reason for disciplinary action, appearing in 46.6% (5,623/12,072) of DARs and accounting for 19.7% (5623/28510) of all documented misconduct cases. Specific professions showed higher negligence rates, such as Veterinary Medicine (29.0% of misconduct) and Respiratory Therapists (26.8% of misconduct). Citations for Incompetence (Appendix B- 16221(b)) increased markedly, from 3.2% in 2011 to 17.6% in 2023, whereas Violation of General Duty (see Appendix B- 16221(a)) steadily declined from 18.0% (316/1,758) in FY2011 to zero usage in FY2022.

Failure to Meet Continuing Education Requirements (see Appendix B- 16221(h)) appeared as the sole infraction in over 18% (2,250/12,072) of orders. The number of orders related exclusively to Failure to Meet Continuing Education Requirements was most prominent in Dentistry and Social Work, constituting 44.5% (327/735) and 44.0% (439/997), respectively.

Trends in Sex-Related Misbehavior

The data reveal marked disparities in rates of sex-related misbehavior across all professions (Figure 3). Nurses, representing 43.8% (5,285/12,072) of orders, were involved in only 28.5% (16/56) of criminal sexual conduct cases and 13.8% (25/181) of sexual misconduct cases. In contrast, massage therapists, although comprising only 0.8% (94/12,072) of the total orders, accounted for 14.3% (8/56) of criminal sexual conduct cases and 9.9% (18/181) of sexual misconduct cases, highlighting a relatively high rate within this profession. Within the physicians (MD and DO), approximately 3.3% (71/2,103) of

Figure 3
Rates of Sex-Related Misbehavior and All Misconduct by Profession



sanctions involved sex-related misbehavior. However, 17.0% (16/94) of all disciplinary orders against massage therapists involved sex-related misbehavior.

Discussion

Data-driven analyses of healthcare provider misconduct are rare in the literature despite their straightforward utility. Our data highlighted several areas of concern and likely improvement. Improving regulatory oversight of healthcare provider misconduct requires a multifaceted approach that incorporates the systematic improvement of the regulatory process, increased transparency in misconduct reporting, preventive education requirements, adequate resource allocation, and the establishment of collaborative information-sharing frameworks.

1) Improve Systemic Regulation of Misconduct

The current framework for reporting healthcare provider misconduct, particularly in Michigan, has significant limitations. While meeting statutory obligations, LARA's DARs are presented in static PDF formats, making them challenging to search, analyze, and use effectively for tracking trends or comparing misconduct across professions. Other states model more usable formats of similar data. For example, Delaware launched an Open Data Portal[7,8] in 2016, enabling public access to and analysis of various government datasets. It has bolstered transparency and strengthened trust between the state and its citizens. Similarly, California's Medical Board maintains an online, searchable database that enables the public to review disciplinary actions taken against healthcare providers. These examples present potential frameworks that Michigan could consider enhancing its public-facing reporting system.[9]

Beyond the limitations of the reporting system, broader systemic factors contribute to the persistent challenge of regulating healthcare provider misconduct. An important barrier is the institutional culture within many healthcare organizations, which may prioritize protecting the institution over patient safety.[10] Research has shown that hospitals and clinics may delay reporting misconduct or shield providers from scrutiny to avoid legal liability and reputational damage. The cases of Robert Anderson[11], the University of Michigan physician who sexually assaulted patients, and Christopher Duntsch[12], the incompetent neurosurgeon who became popularly known as "Dr. Death," illustrate how institutional reluctance to confront misconduct directly can allow problematic providers to continue practicing for years within communities despite their risk to patients.

Additionally, inconsistent categorization and terminology impede efforts to assess and address patterns of professional violations. These limitations underscore the need for a more dynamic and standardized reporting system that enables regulatory agencies and researchers to extract actionable insights. Over time, the terminology used to describe misconduct has shifted, as evidenced by the forms of misconduct commonly cited early in the study period no longer appearing by the end of the study period. For example, prescribing misconduct could have been categorized as "overdispensing" or "overprescribing" between 2016 and 2018. "Overdispensing" and "overprescribing" have not been used since 2018, and it is unclear how similar types of misconduct are now categorized. New categories of misconduct were statutorily created during the data period. For example, "failure to comply with subpoena" is a new category of misconduct, first used in 2019.

2) Emphasize Preventive Education and Ethical Training

Regulatory boards should integrate robust training in ethical and professional behavior across all healthcare professions. Early and sustained ethical training can reduce misconduct by reinforcing professional integrity and accountability.[13] Educational programs incorporating case studies on ethical violations and emphasizing professional expectations can better equip healthcare providers to avoid unethical behaviors.[14] By embedding these guidelines into training and continuous professional development, boards can foster a culture of ethical practice that emphasizes prevention over punishment, ultimately reducing the frequency of severe ethical breaches.[15]

3) Enhance Collaboration with Law Enforcement

In instances of healthcare provider misconduct, particularly those involving criminal activity, a coordinated response is required between regulatory boards and law enforcement agencies. Ideally, boards uphold and enforce professional standards, while law enforcement can address criminal infractions, ensuring a comprehensive approach to public safety.[16] Formalizing partnerships and information-sharing protocols

2025 Federation of State Medical Boards

can enhance regulatory oversight by allowing cases of criminal misconduct, such as fraud or abuse, to be handled swiftly and effectively. Proactive collaboration also enables regulatory boards to focus on the professional aspects of misconduct while ensuring that serious violations face appropriate legal consequences.[15]

4) Adopt Continuous Monitoring and Auditing of Misconduct Patterns

Finite resources available for regular audits and periodic reviews of disciplinary data may hinder regulatory boards from detecting emerging trends, evaluating the effectiveness of sanctions, and identifying areas that require policy refinement. However, evidence suggests that healthcare boards can benefit from implementing metrics to assess outcomes of sanctions and educational interventions, allowing data-informed adjustments to regulatory practices.[15] Continuous monitoring supports a dynamic regulatory environment, where policies evolve in response to changes in healthcare practice and provider demographics, promoting adaptive oversight that keeps pace with industry standards and societal trends.[17]

Study Limitations

This study has several limitations that warrant consideration. First, DARs lack demographic information, such as age, gender, and race, which limits the ability to assess whether specific demographic groups disproportionately complained against or, ultimately, were disciplined. Additionally, DARs do not distinguish between provider specializations within professions (e.g., psychiatrists vs. surgeons, RNs vs. NPs), limiting detailed analysis of variations between subspecialties.[17] Furthermore, DARs document only final disciplinary reports, omitting details about the complaints, complainants, investigative process, and cases dismissed or resolved without formal sanctions. This limits insight into the broader regulation landscape and the factors influencing disciplinary decisions.

Our findings are specific to Michigan, and the generalizability of these findings is unclear. Michigan's political and regulatory environment, the patterns of disciplinary action undertaken, and reported violation types may differ in other jurisdictions, which could impact the applicability of our findings. Trends, such as the prominence of sexual misconduct in particular professions, may reflect broader national patterns; further research is necessary in other state regulatory systems to determine whether these findings are unique to Michigan or indicative of issues in oversight across the US and globally.

Future Directions

There are many different directions that we could go with this data. With unlimited resources, our team would like to explore the frequency and handling of recidivism, as numerous repeat offenders are noted in the database. We also have an interest in exploring the history of the statutes that create and govern the disciplinary subcommittees. Along those lines, each sanctioned instance of misconduct is accompanied by documentation with more specific details on the case. Delving into these documents would likely provide valuable insight and clarity into the terminology used to classify the cases.

Future research should address the limitations identified by the study by incorporating demographic data of the individuals sanctioned and including data from complaint records to better understand healthcare provider misconduct and, perhaps more importantly, public perceptions of these issues.

DATA-DRIVEN ANALYSES OF HEALTHCARE PROVIDER MISCONDUCT ARE RARE IN THE LITERATURE DESPITE THEIR STRAIGHTFORWARD UTILITY. OUR DATA HIGHLIGHTED SEVERAL AREAS OF CONCERN AND LIKELY IMPROVEMENT.

Expanding our analysis to include data from additional states would further illuminate whether the trends observed in Michigan reflect broader national patterns. Such comparative research can provide valuable insights into the relative effectiveness of various regulatory frameworks across jurisdictions.

Another important direction for future work is the role of transparency in reporting. For instance, Delaware's launch of an Open Data Portal in 201618, which enables public access to and analysis of government datasets, has bolstered transparency and strengthened trust between the state and its citizens. Similarly, California's Medical Board provides an online, searchable database that allows the public to review disciplinary actions against healthcare providers, thereby offering a

model of accessibility and public accountability. These examples present potential frameworks that Michigan and other states may consider to improve the reporting system.[7]

Conclusions

This study reports on the patterns of professional misconduct among Michigan healthcare providers between 2011 and 2023. The findings revealed significant disparities in misconduct across different healthcare professions, with particular emphasis on the elevated sexual misconduct rates among certain professions. The data also highlights the challenges of current reporting mechanisms, which are limited by inconsistent categorization, lack of accessibility, and inadequate standardization. These deficiencies hinder meaningful analysis and obscure broader trends in professional misconduct, thereby limiting the effectiveness of regulatory oversight and public scrutiny.

These research findings underscore the need for systemic, technical, and legal changes to improve the transparency and accessibility of misconduct data. Although publicly available, Michigan's DARs are currently challenging to search and analyze because of their static and inconsistent reporting format. Converting these reports into a searchable, structured database with standardized misconduct categories, similar to those used in Delaware or California, would enable better detection of patterns, identification of repeat offenders, and comparative analysis across professions and regions. Such reforms are essential for Michigan and other states to enhance their regulatory processes, which may protect the public and honor healthcare's covenant of trust.

References

1. Crawshaw R, Rogers DE, Pelligrino ED, et al. Patient-physician covenant. JAMA.1995 May 17;273(19):1553. doi:10.1001/jama.1995.03520430089054
2. Blinder A. University of Michigan Will Pay $490 Million to Settle Abuse Cases. *The New York Times*. Published January 19, 2022. Accessed November 3, 2025. https://www.nytimes.com/2022/01/19/sports/ncaafootball/michigan-abuse-settlement-robert-anderson.html
3. Hauser C. Larry Nassar is Sentenced to Another 40 to 125 Years in Prison. *The New York Times*, Published February 5, 2018. Accessed November 3, 2025. 2018. https://www.nytimes.com/2018/02/05/sports/larry-nassar-sentencing-hearing.html
4. Michigan Department of Licensing and Regulatory Affairs. Health License Disciplinary Action Reports. Accessed November 3, 2025. https://www.michigan.gov/lara/bureau-list/bpl/health/dar-reports-health/health-license-disciplinary-action-reports
5. Gumbrecht A. Health Professional Disciplinary Reform FY 2022 Report to the Legislature. Lansing: LARA Bureau of Professional Licensing. Published March 31, 2023. Accessed November 3, 2025. https://www.michigan.gov/lara/-/media/Project/Websites/lara/about/Legislative-Reports/Statutory-Required-Reports/FY2022/BPL--FY22-Health-Professional-Disciplinary-Reform-Report.pdf?rev=0c4b36abf3644298a6b0d79dcc30550f&hash=BBE6AB9EC91061AAFE41736F4906BD3F.
6. Gumbrecht A. FY 2022 Annual Report Board Activities. Lansing: LARA Michigan; Published February 17, 2023. Accessed November 3, 2025. https://www.michigan.gov/lara/-/media/Project/Websites/lara/about/Legislative-Reports/Statutory-Required-Reports/FY2022/BPL--FY22-Board-Activities-Annual-Report.pdf?rev=1767518adf0c48c0bb717f851ff90023&hash=7D22138C60B73A76CEFB4B2A8AA8451E
7. Frerebeau N. Tabula: An R package for analysis, seriation, and visualization of archaeological count data. *Journal of Open Source Software*. 2019 Dec 2;4(44):1821. doi:10.21105/joss.01821
8. Delaware Open Data Portal. Accessed November 3, 2025. https://data.delaware.gov/
9. McNeill M. Health care database comparisons by state. *Dela J of Public Health*. 2022 Dec;8(5):212–214. doi:10.32481/djph.2022.12.045
10. DuBois JM, Carroll K, Gibb TS et al. Environmental factors contributing to wrongdoing in medicine: A criterion-based review of studies and cases. *Ethics Behav*. 2012;22(3):163-188. doi:10.1080/10508422.2011.641832
11. Harding H. UM finalizes $490M settlement with victims of Dr. Robert Anderson. *The Detroit News*. Published 16, 2022. Accessed November 3, 2025. https://www.detroitnews.com/story/news/education/2022/09/16/um-finalizes-490-m-settlement-those-abused-anderson/10401762002/
12. Beil L. A surgeon so bad it was criminal. *ProPublica*. Published October 2, 2018. Accessed November 3, 2025. https://www.propublica.org/article/dr-death-christopher-duntsch-a-surgeon-so-bad-it-was-criminal
13. Lombarts KM, Plochg T, Thompson CA, Arah OA. Measuring professionalism in medicine and nursing: Results of a European survey. *PLoS ONE*. 2014 May 21;9(5). doi:10.1371/journal.pone.0097069
14. Wyatt TR, Jain V, Ma TL. When I stood up for something it's because I felt a… moral violation': Trainees' acts of resistance against social harm and injustice. *Med Educ*. 2023 Nov 17;58(4):457–63. doi:10.1111/medu.15256
15. McIntosh T, Pendo E, Walsh HA, et al. What can state medical boards do to effectively address serious ethical violations? *Journal of Law, Medicine & Ethics.* 2023;51(4):941–53. doi:10.1017/jme.2024.6
16. Faber SC, Wu E, Bartlett A. Abuse of power in the disciplinary actions of a State Psychology Licensing Board: Inequitable outcomes and early career psychologists. *Front Psych*. Sept 14;14. doi:10.3389/fpsyg.2023.1184528
17. Hudspeth R. Understanding discipline of nurse practitioners by Boards of Nursing. *The Journal for Nurse Practitioners*. 2009 May;5(5):365–71.doi:10.1016/j.nurpra.2009.01.001
18. Department of State Delaware, Division of Professional Regulation. Disciplinary actions for professional and occupational licensees. Delaware Open Data Portal. Accessed November 3, 2025.

 2025 Federation of State Medical Boards

About the Authors

Nicole Alvarez, BS, is a fourth-year medical student, Western Michigan University Homer Stryker MD School of Medicine, Kalamazoo, MI

Tyler S. Gibb, JD, PhD, is an Associate Professor, Clinical Ethicist, and Co-Chair, Department of Medical Ethics, Humanities & Law, Western Michigan University Homer Stryker MD School of Medicine, Kalamazoo, MI

Correspondence should be addressed to: Tyler S. Gibb, JD, PhD, Department of Medical Ethics, Humanities & Law, Western Michigan University Homer Stryker MD School of Medicine, 1000 Oakland Drive, Kalamazoo, MI, 269-337-6557; e-mail: tyler.gibb@wmed.edu

Open Access: © 2025 The Authors. Published by the *Journal of Medical Regulation.* This is an Open Access article under the terms of the Creative Commons Attribution-NonCommercial License (CC BY-NC, https://creativecommons.org/licenses/by-nc/4.0/), which permits use and distribution in any medium, provided the original work is properly cited, and the use is noncommercial.

Funding/support: N/A

Other disclosures: N/A

Author contributions: NA and TSG collaborated on all aspects of this project, including study concept and design, data acquisition, analysis, and interpretation; manuscript drafting and revisions. All authors reviewed and approved the final version.

Acknowledgements: We gratefully acknowledge the important contributions of Drs. Jonathan Ericson, Janani Ahmed, Daniel Ferman, and Bryant Hammershaimb during an early iteration of this project. We also thank the WMed Department of Bioinformatics and Juli McCarroll and Kristin Alyousif from the WMed Department of the Medical Library for their expert support. Finally, we are indebted to our colleagues and the reviewers whose thoughtful feedback helped sharpen and strengthen this project.

Keywords: Healthcare regulation; professional misconduct; medical licensing boards; disciplinary actions; sexual misconduct in healthcare

Received: March 25, 2025; **revision received:** June 4, 2025; **accepted:** June 25, 2025

Appendix A

LARA Bureau of Professional Licensing, Health Professional Licensing, List of Healthcare Boards[1]

Michigan Board of Acupuncture
Michigan Board of Athletic Trainers
Michigan Board of Audiology
Michigan Board of Behavioral Analysts
Michigan Board of Chiropractic
Michigan Board of Counseling
Michigan Board of Dentistry
Michigan Board of Dietitian Nutritionists*
Michigan Board of Genetic Counseling
Michigan Board of Marriage & Family Therapy
Michigan Board of Massage Therapy
Michigan Board of Medicine
Michigan Board of Midwifery
Michigan Board of Nursing
Michigan Board of Nursing Home Administrators
Michigan Board of Occupational Therapy
Michigan Board of Optometry
Michigan Board of Osteopathic Medicine & Surgery
Michigan Board of Pharmacy
Michigan Board of Physician Assistants
Michigan Board of Podiatric Medicine & Surgery
Michigan Board of Psychology
Michigan Board of Respiratory Care
Michigan Board of Sanitarians
Michigan Board of Social Work
Michigan Board of Speech-Language Pathology
Michigan Board of Veterinary Medicine

* At the time of our analysis, the Board of Dietitian Nutritionists had not yet been regulated by LARA.

Appendix B

Michigan Compiled Laws, Public Health Code Act 368 of 1978[1]

333.16221 Investigation of licensee, registrant, or applicant for licensure or registration; hearings, oaths, and testimony; complaint; grounds for proceeding under MCL 333.16226.

Sec. 16221.

Subject to section 16221b, the department shall investigate any allegation that 1 or more of the grounds for disciplinary subcommittee action under this section exist, and may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order the taking of relevant testimony. After its investigation, the department shall provide a copy of the administrative complaint to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:

(a) Except as otherwise specifically provided in this section, a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession.

(b) Personal disqualifications, consisting of 1 or more of the following:

(i) Incompetence.

(ii) Subject to sections 16165 to 16170a, substance use disorder as that term is defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

(iii) Mental or physical inability reasonably related to and adversely affecting the licensee›s or registrant›s ability to practice in a safe and competent manner.

(iv) Declaration of mental incompetence by a court of competent jurisdiction.

(v) Conviction of a misdemeanor punishable by imprisonment for a maximum term of 2 years; conviction of a misdemeanor involving the illegal delivery, possession, or use of a controlled substance; or conviction of any felony other than a felony listed or described in another subparagraph of this subdivision. A certified copy of the court record is conclusive evidence of the conviction.

(vi) Lack of good moral character.

(vii) Conviction of a criminal offense under section 520e or 520g of the Michigan penal code, 1931 PA 328, MCL 750.520e and 750.520g. A certified copy of the court record is conclusive evidence of the conviction.

(viii) Conviction of a violation of section 492a of the Michigan penal code, 1931 PA 328, MCL 750.492a. A certified copy of the court record is conclusive evidence of the conviction.

(ix) Conviction of a misdemeanor or felony involving fraud in obtaining or attempting to obtain fees related to the practice of a health profession. A certified copy of the court record is conclusive evidence of the conviction.

(x) Final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States, by the United States military, by the federal government, or by another country. A certified copy of the record of the board is conclusive evidence of the final action.

(xi) Conviction of a misdemeanor that is reasonably related to or that adversely affects the licensee›s or registrant›s ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence of the conviction.

(xii) Conviction of a violation of section 430 of the Michigan penal code, 1931 PA 328, MCL 750.430. A certified copy of the court record is conclusive evidence of the conviction.

2025 Federation of State Medical Boards

(xiii) Conviction of a criminal offense under section 83, 84, 316, 317, 321, 520b, 520c, 520d, or 520f of the Michigan penal code, 1931 PA 328, MCL 750.83, 750.84, 750.316, 750.317, 750.321, 750.520b, 750.520c, 750.520d, and 750.520f. A certified copy of the court record is conclusive evidence of the conviction.

(xiv) Conviction of a violation of section 136 or 136a of the Michigan penal code, 1931 PA 328, MCL 750.136 and 750.136a. A certified copy of the court record is conclusive evidence of the conviction.

(xv) Conviction of a violation of section 90 of the Michigan penal code, 1931 PA 328, MCL 750.90, or a violation of a state or federal crime that is substantially similar to the violation described in this subparagraph. A certified copy of the court record is conclusive evidence of the conviction.

(c) Prohibited acts, consisting of 1 or more of the following:

(i) Fraud or deceit in obtaining or renewing a license or registration.

(ii) Permitting a license or registration to be used by an unauthorized person.

(iii) Practice outside the scope of a license.

(iv) Obtaining, possessing, or attempting to obtain or possess a controlled substance or a drug as that term is defined in section 7105 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.

(d) Except as otherwise specifically provided in this section, unethical business practices, consisting of 1 or more of the following:

(i) False or misleading advertising.

(ii) Dividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or in behalf of patients.

(iii) Fraud or deceit in obtaining or attempting to obtain third party reimbursement.

(e) Except as otherwise specifically provided in this section, unprofessional conduct, consisting of 1 or more of the following:

(i) Misrepresentation to a consumer or patient or in obtaining or attempting to obtain third party reimbursement in the course of professional practice.

(ii) Betrayal of a professional confidence.

(iii) Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service.

(iv) Either of the following:

(A) A requirement by a licensee other than a physician or a registrant that an individual purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee or registrant has a financial interest.

(B) A referral by a physician for a designated health service that violates 42 USC 1395nn or a regulation promulgated under that section. For purposes of this subdivision, 42 USC 1395nn and the regulations promulgated under that section as they exist on June 3, 2002 are incorporated by reference. A disciplinary subcommittee shall apply 42 USC 1395nn and the regulations promulgated under that section regardless of the source of payment for the designated health service referred and rendered. If 42 USC 1395nn or a regulation promulgated under that section is revised after June 3, 2002, the department shall officially take notice of the revision. Within 30 days after taking notice of the revision, the department shall decide whether or not the revision pertains to referral by physicians for designated health services and continues to protect the public from inappropriate referrals by physicians. If the department decides that the revision does both of those things, the department may promulgate rules to incorporate the revision by reference. If the department does promulgate rules to incorporate the revision by reference, the department shall not make any changes to the revision. As used in this sub-subparagraph, "designated health service" means that

term as defined in 42 USC 1395nn and the regulations promulgated under that section and "physician" means that term as defined in sections 17001 and 17501.

(v) For a physician who makes referrals under 42 USC 1395nn or a regulation promulgated under that section, refusing to accept a reasonable proportion of patients eligible for Medicaid and refusing to accept payment from Medicaid or Medicare as payment in full for a treatment, procedure, or service for which the physician refers the individual and in which the physician has a financial interest. A physician who owns all or part of a facility in which the physician provides surgical services is not subject to this subparagraph if a referred surgical procedure the physician performs in the facility is not reimbursed at a minimum of the appropriate Medicaid or Medicare outpatient fee schedule, including the combined technical and professional components.

(vi) Any conduct by a licensee or registrant with a patient while the licensee or registrant is acting within the health profession for which the licensee or registrant is licensed or registered, including conduct initiated by a patient or to which the patient consents, that is sexual or may reasonably be interpreted as sexual, including, but not limited to, sexual intercourse, kissing in a sexual manner, or touching of a body part for any purpose other than appropriate examination, treatment, or comfort.

(vii) Offering to provide practice-related services, such as drugs, in exchange for sexual favors.

(viii) A violation of section 16655(4) by a dental therapist.

(f) Failure to notify under section 16222(3) or (4).

(g) Failure to report a change of name or mailing address as required in section 16192.

(h) A violation, or aiding or abetting in a violation, of this article or of a rule promulgated under this article.

(i) Failure to comply with a subpoena issued pursuant to this part, failure to respond to a complaint issued under this article, article 7, or article 8, failure to appear at a compliance conference or an administrative hearing, or failure to report under section 16222(1) or 16223.

(j) Failure to pay an installment of an assessment levied under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, within 60 days after notice by the appropriate board.

(k) A violation of section 17013 or 17513.

(l) Failure to meet 1 or more of the requirements for licensure or registration under section 16174.

(m) A violation of section 17015, 17015a, or 17515.

(n) Failure to comply with section 9206(3).

(o) A violation of section 5654 or 5655.

(p) A violation of section 16274.

(q) A violation of section 17020 or 17520.

(r) A violation of the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271.

(s) A violation of section 17764(2).

(t) Failure to comply with the terms of a practice agreement described in section 17047(2)(a) or (b), 17547(2)(a) or (b), or 18047(2)(a) or (b).

(u) A violation of section 7303a(2).

(v) A violation of section 7303a(4) or (5).

(w) A violation of section 7303b.

(x) A violation of section 17754a.

(y) Beginning January 1, 2021, a violation of section 24507 or 24509.

2025 Federation of State Medical Boards