BAD MEDICINE: ON DISCIPLINING PHYSICIAN FELONS

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I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

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If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.[1]

—Hippocratic Oath

I. Introduction

Perhaps it is the white coat or the degrees encased and mounted on the wall. Perhaps it is the Hippocratic Oath that new physicians recite and that established physicians have putatively internalized over time, or perhaps it is the title, "Doctor," which conjures up images of a stethoscope, a black bag, house calls, nurture, and trust.[2] When we are sick, we head to the doctor. Young children are urged to become doctors. When we watch television or go to the movies doctors are, with certain recent exceptions, portrayed in a positive light as compared to lawyers or politicians.[3] In this regard, membership in the profession has its privileges—but also, of course, its obligations. Stressing as much, courts have observed that the state interest in regulating doctors is "especially great" because the physician is in "a position of public trust and responsibility."[4] In this way, it is *because* of the veneration and status they enjoy that physicians are held to the high standards they are—warranting scrutiny that other professionals, even other professions licensed or certified by the state, may not necessarily receive. And yet physicians, like all people, are subject to temptations, aversions, errors in judgment, and missteps. The difference is that when they do err, doctors are punished on two fronts: as citizens who have violated the rules of the state and as licensed professionals who have acted in a manner inconsistent with the terms of their state-conferred privilege.[5] This two-part punitive punch (administered

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1 Hippocratic Oath (modern version), http://www.pbs.org/wgbh/nova/doctors/oath_modern.html (last visited Jan. 6, 2009).

2 We should stress that non-medical "Doctors" (i.e. those holding Ph.D.s) do not enjoy quite the same position in the public mind.

3 Of course, television shows such as "Grey's Anatomy" put on display, for lack of a better word, the "human" side of physicians. Compare this to shows such as the long-running "E.R." and the popular "House," where the main character is irreverent, but still the hero.

4 Boedy v. Dep't of Prof'l Regulation, 463 So.2d 215, 217 (Fla. 1985).

5 *See* Michael S. Kelton, *Collateral Consequences of Criminal Convictions of Physicians*, 19 Atticus 3, 3–4 (2006), *available at* http://www.keltonlawfirm.com/pdf/Kelton_Collateral_Consequences.pdf/. Furthermore:

in both respects by the state or quasi-state entities) is intriguing for a host of reasons.

First, as a function of this status (as persons *and* professionals), one could construe the net severity to be harsher than for a similarly-situated citizen without a professional license. The licensed individual could commit but one offense and receive two punishments, while the non-licensed individual may be admonished in a more congruent one-for-one manner. Second, the relationship between the effects of the license and the ultimate outcome could actually cut the other way (toward a less harsh response), where the licensed individual receives an ultimate punitive impact of *less* than that accorded to the similarly-situated, non-licensed "control" subject. Consider, for example, that *because* the license is potentially in jeopardy, the criminal court may be *less* harsh than it would otherwise be—even as the licensing board may itself be *less* harsh in its sanction of the individual owing to the assumption that the criminal penalty will be more severe than it would be for a non-licensed individual. One might think of this as a kind of "mutual mitigation," where the anticipated—or perhaps imagined—consequences coming on *both* fronts (criminal and review board) work to temper the conclusions reached within each individual domain, such that the net severity of the punishment is actually *less* than it would be if the processes were entirely discrete.

Third, within the American federal system, "police powers" are theoretically reserved for the state and local level,[6] where most matters of professional licensing are also maintained.[7] This means

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> [C]riminal prosecutions can and do intersect with, and directly affect, a physician's license . . . . A criminal conviction, especially a felony conviction, even though totally unrelated to the practice of medicine, will impact the physician's license, and may result in a revocation of that license . . . . [O]ne serious consequence of a felony conviction is exposure to an immediate suspension of the physician's license to practice medicine pending his hearing. This is because the physician, having been found guilty of a felony, no longer maintains the presumption of innocence, as he has already committed serious professional medical misconduct simply based upon the conviction itself.

Id.

6 *See, e.g.,* New York v. Miln, 36 U.S. 102 (1837).

7 *See, e.g.,* J. F. Barron, *Business and Professional Licensing—California, a Representative Example*, 18 STAN. L. REV. 640 (1966) (clarifying the economic rationale of licensing as an example of the police power and considering alternative methods); Also:

> Although statutory regulation of the professions may take many forms, licensure has been the basic vehicle used in the United States . . . . It is absolutely essential to recognize that licensing laws are not meant to ensure a high level of professional competence, only that a practitioner is not likely to harm the public.

Daniel B. Hogan, *The Effectiveness of Licensing: History, Evidence, and Recommendations*, 7 LAW & HUM. BEHAV. 117, 134 (1983); Finally:

that states have the potential to act as "laboratories"[8] by crafting their own standards for the profession and their own responses to infractions. In other words, with these varying "political cultures"[9] and "legal cultures,"[10] we would expect variance in states' punitive responses. Attorneys convicted of felonies in New York, for example, automatically lose their licenses once the conviction is a matter of public record (disbarment proceedings are a formality),[11] though our previous study of disciplinary law and politics in New Jersey indicates that the Garden State is anything but categorical in its handling of attorney felony offenders.[12] Thus even adjacent states such as New York and New Jersey, who likely share vast numbers of licensed professionals, do not maintain the same or even similar policies for disciplining offenders. Because physicians often hold licenses in multiple states, we examine the extent to which punishments are reciprocal for offending doctors. Specifically, to what degree do autonomous state entities generally abide by the outcomes reached in other, "sister" states? Is there an institutional incentive to be more, less, or about the same in terms of the severity of the punishment? Studies of federalism have shown evidence of a "race to the bottom" effect where states seek to reach the minimum required in the way of procurement of services or regula-

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> Since colonial times, the regulation of professions has been seen as a state activity in the United States" and noting that "[m]edicine is a particular creature" of regulation because "it is the nexus of three traditional areas of police power regulation" in that it is a "profession like law" and thus subject to regulation, but also because medical practitioners "posed peculiar risks to the public health and safety that other professions such as law did not pose" and because "physicians have been closely involved in the state public health regulations as they applied to epidemic disease and sanitation," a role wherein doctors "acted both as private volunteers and as public health officers."

Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 202–03 (1999)

8 *See* New State Ice Co. v. Liebman, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

9 *See, e.g.,* DANIEL ELAZAR, AMERICAN FEDERALISM (3d ed. 1984).

10 *See* Thomas Church, Jr., *Examining Local Legal Culture*, 3 AM. B. FOUND. RES. J. 449 (1985); Milton Heumann, *Thinking About Plea Bargaining*, *in* THE STUDY OF CRIMINAL COURTS 210–214 (Peter Nardulli ed., 1979).

11 Kelton, *supra* note 5.

12 *See* Brian Pinaire et al., *Barred from the Bar: The Process, Politics, and Policy Implications of Discipline for Attorney Felony Offenders,* 13 VA. J. SOC. POL'Y & L. 290 (2006).

tion of interests.[13] States may then, as part of this race, not only match but exceed each other with respect to their penalties. On the other hand, they may attempt to *exceed* one another in their efforts to preserve the public welfare in this regard—i.e. a kind of "race to the top."

Such questions and concerns flow from recent research that has begun to focus in more detail on the distinctly *political* impulses of various punitive institutions,[14] practices,[15] and policies,[16] including the processes of discipline for professional offenders[17] and the array of "collateral consequences" that confront all individuals convicted of felonies and, in certain cases, misdemeanors.[18] Fixing on such general "consequences"—"invisible punishments" for one researcher,[19] "invisible stripes" for a former prison war-

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13 *See* William L. Cary, *Federalism and Corporate Law: Reflections upon Delaware*, 83 YALE L.J. 663 (1974) (arguing that legitimate regulatory laws may be curtailed by states competing with other states to attract business).

14 *See* G. GELTNER, THE MEDIEVAL PRISON: A SOCIAL HISTORY 5 (2008) (arguing that the creation of medieval prisons, especially in their physical and administrative organization, "reveals an impulse not simply to eradicate, but rather to *contain* and *maintain* deviancy").

15 *See* JOAN PETERSILIA, WHEN PRISONERS COME HOME (2003) (reviewing the various legal, political, and communal barriers to effective reentry of offenders released from incarceration); David Garland, *Penal Excess and Surplus Meaning: Public Torture Lynchings in Twentieth-Century America*, 39 LAW & SOC'Y REV. 793, 801 (2005) (arguing that public torture lynching common in the American south in the early part of the 20th century was a "self-consciously excessive retributive ritual ('penal excess')" and a "strategic means adopted by political actors to communicate meanings and sentiments that went well beyond the bounds of criminal justice in their intended significance ('surplus meaning')").

16 *See* TED GEST, CRIME AND POLITICS 41–62 (2004) (discussing "get tough" and "just deserts" approaches to crime and punishment in modern America); MARIE GOTTSCHALK, THE PRISON AND THE GALLOWS: THE POLITICS OF MASS INCARCERATION IN AMERICA 236 (2006) (contending that the "carceral state" in America is distinguished by three features: "the sheer size of its prison and jail population; its reliance on harsh, degrading sanctions; and the persistence and centrality of the death penalty" and arguing that the development of this state had multiple and "dispersed" causes that pre-date the 1960's); Marie Gottschalk, *Hiding in Plain Sight: American Politics and the Carceral State*, 11 ANN. REV. POL. SCI. 235 (2008) (discussing the emergence and development of the carceral state and particularly the assumption by the state of control of millions more people and the change in the distribution of authority to law enforcement over the past few decades).

17 *See* Brian Pinaire et. al., *supra* note 12; Milton Heumann et al., *Prescribing Justice: The Law and Politics of Discipline for Physician Felony Offenders*, 17 B.U. PUB. INT. L.J. 1 (2007).

18 *See* Symposium, *Twelfth Annual Symposium on Contemporary Urban Challenges: Beyond the Sentence: Post-Incarceration Legal, Social, and Economic Consequences of Criminal Convictions*, 30 FORDHAM URB. L.J. 1491 (2003) (a compilation of recent scholarly attention directed toward punishments "beyond the sentence" for felons *as a class* of offenders in the American criminal justice system); Milton Heumann et al., *Beyond the Sentence: Public Perceptions of Collateral Consequences for Felony Offenders*, 41 CRIM. L. BULL. 24, 29–30 (2005).

19 *See* JEREMY TRAVIS, BUT THEY ALL COME BACK (2005) (discussing the varieties and significance of the "invisible punishments" that impede effective reentry of criminal offenders);

den,[20] and the "Mark of Cain"[21] or a status of "internal exile"[22] for others—allows us to appreciate in a more profound sense the true implications of punishments beyond the sentence. If the government can restrict or rescind an individual's right to vote[23] (rendering the afflicted "civilly dead"[24] and influencing electoral

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INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT 15 (Marc Mauer & Meda Chesney-Lind eds., 2002). *But see also* Alec C. Ewald & Marnie Smith, *Collateral Consequences of Criminal Convictions in American Courts: The View from the State Bench*, 29 JUST. SYS. J. 145 (2008) (questioning the conventional wisdom that collateral consequences are "invisible" to the affected parties with empirical data drawn from surveys of courtroom practitioners).

[20] *See* LEWIS E. LAWES, INVISIBLE STRIPES 298 (1938). Referring to a query considered earlier in the book, former Sing Sing warden Lewis Lawes writes:

> We know now why men "come back to prison a second, third or fourth time" . . . . [It is] because society lacks faith in its own measures for rehabilitation . . . [and because] the prisoner, on his discharge from prison, is conscious of invisible stripes fastened upon him by tradition and prejudice.

Id.

[21] *See* Hugh LaFollette, *Collateral Consequences of Punishment: Civil Penalties Accompanying Formal Punishment*, 22 J. APPLIED PHIL. 241, 242 (2005) ("The scope and significance of . . . collateral consequences show that the real world of punishment is far different from the one most people imagine. In *this* world a felon's debt to society is rarely paid in full. For these felons the Mark of Cain is permanent."). *See also* Webb Hubbell, *Without Pardon: Collateral Consequences of a Felony Conviction*, 13 FED. SENT'G REP. 223 (2000–2001) (relying on personal experience(s) to argue that having a felony record is the "mark of Cain" that "shackles former offenders" with restrictions barring them from "the means to live a normal life.").

[22] Nora Demleitner, *Preventing Internal Exile*, 11 STAN. L. & POL'Y REV. 153, 154 n.17 (1999) (In America, "[e]ven when the sentence has been completely served, the fact that a man has been convicted of a felony pursues him like Nemesis." (quoting National Council on Crime and Delinquency, *Annulment of a Conviction of Crime: A Model Act*, 8 CRIME & DELINQ. 97, 98 (1962))).

[23] *See* Brian Pinaire, et al., *Barred from the Vote: Public Attitudes Toward the Disenfranchisement of Felons*, 30 FORDHAM URB. L.J. 1519 (2003) (discussing the laws in place in 2001 that restricted or rescinded the right to vote for convicted felons in each of the fifty states and offering the first-of-its kind national survey data indicating that the American public is overwhelmingly opposed to a permanent prohibition on voting by those with felony records); Jeff Manza et al., *Public Attitudes Toward Felon Disenfranchisement in the United States*, 68 PUB. OPINION Q. 275 (2004) (finding that in most cases, the public views the voting restrictions on ex-felons as violation of the ex-felons' civil liberties); JEFF MANZA & CHRISTOPHER UGGEN, LOCKED OUT: FELON DISENFRANCHISEMENT AND AMERICAN DEMOCRACY (2006).

[24] *See* Alec Ewald, *Civil Death: The Ideological Paradox of Criminal Disenfranchisement Law in the United States*, WIS. L. REV. 1045, 1060 (2002) (noting that "English colonists in North America transplanted much of the mother country's common law regarding the civil disabilities of convicts, and supplemented it with statutes regarding suffrage;" arguing that the persistence of criminal disenfranchisement in the United States is explained by the combination of contractarian-liberal, civic-virtue republican, and racially discriminatory ideologies in the United States and contending that the principles of both liberalism and republicanism pose powerful challenges to the practice). *But see* Christopher Manfredi, *Judicial Review and Criminal Disenfranchisement in the United States and Canada*, 60 REV. POL. 277 (1998) (offering a defense of criminal disenfranchisement rooted in the relationship between citizenship, civic virtue, and punishment).

outcomes[25]), and the rights to run for or stay in elected office,[26] to serve on a jury,[27] to own a firearm,[28] to become licensed or certified in certain trades or professions,[29] to reside in public housing,[30] to procure student loans,[31] or to serve in the military,[32] among other things—all owing to a criminal record, even if not formally "imposed" by the state[33]—then clearly punishments transcend a

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[25] *See* Christopher Uggen & Jeff Manza, *Democratic Contraction? Political Consequences of Felon Disenfranchisement in the United States*, 67 AM. SOC. REV. 777 (2002) (finding that the disenfranchisement of felons played a "decisive role" in U.S. Senate elections in recent years and would have reversed the victory of one Republican presidential candidate, while "jeopardizing" the victory of at least one Democratic president). *But see* Thomas Miles, *Felon Disenfranchisement and Voter Turnout*, 33 J. LEGAL STUD. 85 (2004) (contending that estimates of turnout reveal that disenfranchisement has no discernible effect on state-level rates of voter turnout and concluding therefore that the impact of such laws may be more modest than previously thought).

[26] *See generally* MARGARET COLGATE LOVE, RELIEF FROM THE COLLATERAL CONSEQUENCES OF A CRIMINAL CONVICTION: A STATE-BY-STATE RESOURCE GUIDE 6 (2005), *available at* http://www.wshein.com/media/Catalog/3/334160.pdf; Andrea Steinacker, *The Prisoner's Campaign: Felony Disenfranchisement Laws and the Right to Hold Public Office*, 2003 BYU L. REV. 801 (surveying state-by-state legislation disqualifying felons from holding office); Steven B. Snyder, *Let My People Run: The Rights of Voters and Candidates Under State Laws Barring Felons from Holding Elective Office*, 4 J.L. & POL. 543 (1988) (decrying state statutes barring those with felony records from holding elective office). *But see* James A. Gathings, *Loss of Citizenship and Civil Rights for Conviction of Crime*, 43 AM. POL. SCI. REV. 1228 (1949) (discussing the case of Boss Curley in Boston who was convicted in federal court but who retained his office as mayor and continued to draw a salary even while incarcerated because local and state laws, which govern elections and eligibility did not preclude him from doing so).

[27] *See* Brian C. Kalt, *The Exclusion of Felons from Jury Service*, 53 AM. U. L. REV. 67 (2003) (describing and critiquing state legislation barring those with felony records from serving on juries in the majority of states).

[28] *See* Gun Control Act of 1968, Pub. L. No. 90-618, 82 Stat. 1213 (codified as amended at 18 U.S.C. §§ 921–931 (2006))

[29] *See* TODD CLEAR & GEORGE COLE, AMERICAN CORRECTIONS (2d ed. 1999) (noting that all fifty states put restrictions on convicted felons seeking to become barbers or beauticians); Love, *supra* note 26.

[30] Kathleen Olivares et al., *The Collateral Consequences of a Felony Conviction: A National Study of State Legal Codes 10 Years Later,* 60 FED. PROBATION 13 (1996) (providing a descriptive overview of the range of penalties and burdens imposed on those with felony records beyond their formal sentences).

[31] *Id.*

[32] 10 U.S.C. § 504 (2006); 50 U.S.C. app. § 456(m) (2006).

[33] *See* Harry Holzer et al., *Will Employers Hire Former Offenders?: Employer Preferences, Background Checks, and their Determinants*, *in* IMPRISONING AMERICA 205, 209 (Mary Pattillo et al. eds., 2004) (reporting results from a telephone survey of large metropolitan areas finding that more than 60 percent of employers indicated that the would "probably not" or "definitely not" be willing to hire an applicant with a criminal record, with "probably not" as the modal response); *see also* ANNIE PIEHL, CRIME, WORK, AND REENTRY, URBAN INSTITUTE REENTRY ROUNDTABLE DISCUSSION PAPER 13 (May 19-20, 2003), *available at www.urban.org/UploadedPDF/410856_Piehl.pdf* ("Given the obstacles to finding full-time, long-term employment, it is also likely that many ex-inmates who work will continue to engage in a mix of legal and illegal activities.").

mere calculation of the "time" served in traditional sentencing terms. Given the state's governance of trade and professional opportunities, it is not surprising that a criminal conviction—or merely an arrest—can have a profound influence on an individual's long term employment potential.[34] Indeed, one commentator has mused that "[i]n some states virtually the only 'profession' open to an ex-felon is that of burglar."[35]

Against this backdrop, this Article presents the first-ever comprehensive analysis of the legal and political disciplinary processes for physician felony offenders in the state of New York. With the Empire State as our case study, we begin in Part II with a discussion of the state's general authority over matters of licensing and certification, with attention to the history of the regulation of medicine in the United States, and with an overview of the particular powers of New York State entities. Following this, in Part III, we focus in greater detail on the administration of justice, tracing the process through the complaint stage to the actual adjudication of cases. Part IV affords us the opportunity to discuss our research methods, findings, and assessments. It is here that we present the data drawn from our time-series analysis, coding, and interviews with elites involved with the disciplinary process. This sets the stage for Part V where we contemplate the implications of this research for our understanding of punishments for professionals in American society. Finally, in Part VI, we pose some questions for future study and contemplate the general lessons to be drawn from our case study of New York State.

II. Public Health

Occupational licensing is designated as "a process where entry into an occupation requires the permission of the government, and the state requires some demonstration of a minimum degree of competency."[36] Generally, a nongovernmental licensing board is

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[34] *See* Bill Hebenton & Terry Thomas, Criminal Records: State, Citizen, and the Politics of Protection 111 (1993) (noting that federal or state laws bar or restrict the employment of ex-offenders in approximately 350 occupations, affecting about ten million individuals).

[35] Bruce May, *Real World Reflection: The Character Component of Occupational Licensing Laws,* 71 N.D. L. Rev. 187, 193 (1995).

[36] Morris M. Kleiner, *Occupational Licensing*, 14 J. Econ. Persp. 189, 191 (2000). *See also* Anthony C. Thompson, *Navigating the Hidden Obstacles to Ex-Offender Reentry*, 45 B.C. L. Rev. 255, 280 (2004) ("Professional licensing is the primary method for maintaining some measure of regulatory control over professional qualifications and over the quality of service pro-

established by the state, with members of the profession, political appointees, and members of the public sitting in review of those desiring admission.[37] Significantly, a trade or occupational license is not considered to be one's "property"[38] and is decidedly not a "right," but rather is generally construed as a *privilege* afforded by the government that allows an applicant for a license to engage in activities otherwise not allowed without the license.[39] It is "permission," if you will, from the government to enter into an occupation where some minimum degree of competency is required and where governance is generally carried out by nongovernmental boards

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vided by individuals within that business."). Licensing in the modern state has developed to the point where regulatory requirements now implicate at least 6,000 different occupations. *See* PETERSILIA, *supra* note 15, at 114. Indeed, one recent assessment finds that eighteen percent of U.S. workers are directly affected by occupational licensing requirements, a figure "which is more than either the minimum wage, which has a direct impact on less than 10 percent of workers[,] . . . or unionization, whose membership rates are now less than 15 percent of the labor force." Kleiner, *supra,* at 190. For more on the development of licensing restrictions, see LAWRENCE FRIEDMAN, A HISTORY OF AMERICAN LAW 454–57 (1985) (paying particular attention to the period at the end of the nineteenth century and stressing the vigor with which the motivation for such licenses was contested by the variously affected parties).

[37] Kleiner, *supra* note 36, at 191. *See also* NEW JERSEY DIVISION OF CONSUMER AFFAIRS, STATE BOARD OF MEDICAL EXAMINERS, BOARD HISTORY, *available at* http://www.state.nj.us/oag/ca/bme/board/history.htm.

[38] William Gunnar, The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?, 14 ANNALS HEALTH L. 329 (2005) (discussing the notion of a medical license as a "property right," as well as varying standards of evidence in the states); Tara Widmer, South Dakota Should Follow Public Policy and Switch to the Preponderance Standard for Medical License Revocation After In Re The Medical License of Dr. Reuben Setliff, M.D., 48 S.D. L. REV. 388, 398–99 (2003) (demonstrating that states are "split as to the standard of proof necessary for a state medical board to revoke a physician's license," with some holding that a license may only be revoked with "clear and convincing evidence"—recognizing the license as "property" and thus warranting due process protections—though the majority of states require boards to base decisions only on the "preponderance of evidence" standard, taking the position that "the licensee should bear the risk of error, rather than the public").

[39] Leroy Clark, *A Civil Rights Task: Removing Barriers to Employment of Ex-convicts*, 38 U.S.F. L. REV. 193, 194–96 (2004):

> Under licensing laws, an individual is granted a privilege by the state (and not a right) to engage in particular occupations. Licensing laws come in two forms: revenue raising and regulatory. Generally, revenue raising license laws are merely tax measures. The applicant secures the license by paying a fee, and the state does not inquire into the applicant's background or competence to perform particular tasks. Regulatory license laws, however, are an exercise of the state's police powers designed to protect the public's health, safety, and welfare . . . . Ex-offenders are excluded by statute not only from licensed occupations, but also from many forms of public employment with federal and state agencies. One study shows that federal and state laws bar or restrict employment of ex-offenders in approximately 350 occupations, which employ ten million persons.

Id.

comprised of political appointees, practitioners, and members of the public.[40]

Occupational *certification*, however, while also involving the administration of some sort of examination to demonstrate proficiency (which garners certification), is associated with jobs that may be performed by individuals both certified and uncertified (e.g. mechanics). By contrast, occupations requiring a license may *only* be legally performed by those who have met the government's requirements for such status (e.g. physicians).[41] In this sense, a doctor is whomever the state acknowledges as such, and this requisite recognition dates back to the earliest days of this nation. In fact, as one recent analysis has detailed, while at common law the practice of medicine was open to all, the American colonies began to regulate various elements of the medical practice as early as 1639 with a Virginia law governing fees and quarantines.[42] Still, it was not until 1760 that a U.S. jurisdiction, New York City, actually began requiring medical licensing examinations.[43] Other cities and states followed, and, by 1830, the only states *without* statutes requiring governmental licensure or providing for the authorization of state examining boards were Pennsylvania, North Carolina, and Virginia.[44]

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[40] *See* Kleiner, *supra* note 36, at 191. The state's prerogative in regulating admission has also been emphasized by the United States Supreme Court in *Dent v. W. Va.*, wherein Justice Field acknowledged that while citizens have the "right" to "follow any lawful calling, business, or profession . . . subject only to such restrictions as are imposed upon all persons of like age, sex, and condition," no arbitrary deprivation of that right exists "where its exercise is not permitted because of a failure to comply with conditions imposed by the State for the protection of society." Indeed, a state's power to provide for the general welfare "authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud." 129 U.S. 114, 121 (1889). *See also* Lawrence v. Bd. of Registration in Med., 132 N.E. 174, 176 (Mass. 1921) ("The right of a physician to toil in his profession . . . with all its sanctity and safeguards is not absolute. It must yield to the paramount right of government to protect the public health by any rational means.").

[41] Kleiner, *supra* note 36, at 191; BENJAMIN SHIMBERG ET AL., OCCUPATIONAL LICENSING: PRACTICES AND POLICIES 9 (1973) (distinguishing between *licensing*, which is "a generic term which encompasses all forms of regulation that give the licensed practitioner the legal authority to engage in his occupation or profession," and *certification*, which "rarely implies governmental or legal sanction" and is more akin to a recognition by an agency or association that an individual has met predetermined qualifications).

[42] Gregory Dolin, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 GEO. J.L. & PUB. POL'Y 315, 316 (2004).

[43] *See* ROBERT DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 9 (1969); RICHARD SHRYOCK, MEDICAL LICENSING IN AMERICA 1650–1965, at 17 (1967); Dolin, *supra* note 42, at 316.

[44] Dolin, *supra* note 42, at 316.

Drawing on such momentum, the American Medical Association ("AMA") was formed in 1846 with the purpose of improving the quality of the profession and the education that sustained it.[45] While the AMA worked to expand governmental intervention in, and scrutiny of, the practice of medicine throughout the latter half of the 1800's, it was not until the early twentieth century that legislatures throughout the country accepted this charge and established some version of a medical practice act, delegating the enforcement of the law to state medical boards.[46] As of now, there are a total of seventy state boards authorized to regulate allopathic and/or osteopathic physicians,[47] handling the licensing of physicians, the investigation of complaints, the discipline of physicians and, where appropriate, the rehabilitation of offending physicians.[48]

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45 *See* American Medical Association, Illustrated Highlights, http://www.ama-assn.org/ama/pub/about-ama/our-history/illustrated-highlights.shtml (last visited Oct. 18, 2007).

46 *See* Sue A. Blevins, *The Medical Monopoly: Protecting Consumers or Limiting Competition*, CATO INST. POLICY ANALYSIS No. 246 (1995), *available at* http://www.cato.org/pubs/pas/pa-246.html; Mitch Altschuler, Note, *The Dental Health Care Professionals Nonresidence Licensing Act: Will It Effectuate The Final Decay Of State Discrimination Against Out-Of-State Dentists?,* 26 RUTGERS L.J. 187, 193 (1994); Richards, *supra* note 7, *passim*. STANLEY GROSS, OF FOXES AND HEN HOUSES 57–58 (1984). A "wake up" call of sorts for the state's role in this tandem effort came in the form of the "Flexner Report," an assessment of medical education in the United States and Canada commissioned by the Carnegie Foundation. *See* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910), *available at* http://www.carnegiefoundation.org/sites/default/files/elibrary/Carnegie_Flexner_Report.pdf. As a result of this influential evaluation, which found medical training to be generally lacking in standards and improperly oriented toward profits, thirty-nine states created examining boards to require the licensing of physicians as opposed to merely accepting diplomas as *prima facie* evidence of competency. *See* Altschuler, *supra*, at 193.

47 The establishment in 1912 of the Federation of State Medical Boards helped to standardize both licensing procedures and medical school curricula, eventually leading to the formation of the National Board of Medical Examiners in 1915. *See* Altschuler, *supra* note 46, at 193; PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 104 (1982). By 1994, the three-step United States Medical Licensing Examination ("USMLE") was the required exam for licensure in all fifty states. *See* Dolin, *supra* note 42, at 319. To sit for the USMLE exam, one must have graduated from an accredited medical school, and, depending on the state, one must also complete between one to three years of infra-graduate medical training—typically known as a "residency"—in a program that has been approved by the Accreditation Council for Graduate Medical Education. Significantly, these accrediting associations are private organizations that set standards that are not reviewed by state or federal governments and that are immune from judicial challenge. Moreover, while states are not *required* to accept the results of the board exams, all of them do. This effect cedes a significant degree of licensing authority to the private associations—and the physicians who populate these groups—that serve as the gatekeepers to the profession. *Id.*

48 *See* FEDERATION OF STATE MEDICAL BOARDS, TRENDS IN PHYSICIAN REGULATION 14 (2006), *available at* http://www.fsmb.org/pdf/PUB_FSMB_Trends_in_Physician_Regulation_

We turn now to the administrative framework established to preserve the public health of the citizens of New York State.[49] Since 1976, the licensing and disciplinary processes in the Empire State have been separate, with licensing controlled by the Department of Education[50] ("DOE") and with disciplinary matters attended to by the Office of Professional Medical Conduct

2006.pdf. "State medical boards license physicians, investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians where appropriate," thus giving the public "a way to enforce basic standards of competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession." *Id.* Significantly, "[w]hile medical boards sometimes find it necessary to suspend or revoke licenses, regulators have found many problems can be resolved with additional education or training in appropriate areas," though "[i]n other instances it may be more appropriate to place physicians on probation or place restrictions on a physician's license to practice"—which is a "compromise" that "protects the public while maintaining a valuable community resource in the physician." *Id.*

49 Over one hundred occupations in New York State require some type of license, registration, or certification by a state agency. *See* Legal Action Center, *New York State Occupational Licensing Survey* 1 (2006), *available at* http://lac.org/doc_library/lac/publications/Occupational%20Licensing%20Survey%202006.pdf. Article 23-A of the New York Corrections Law (N.Y. CORRECT. LAW, §§ 750–755 (Consol. 2009)) and the New York State Human Rights Law (N.Y. EXEC. LAW § 296(15) (Consol. 2009)) prohibit employers from maintaining policies that categorically exclude "all felons" or "all ex-offenders," although employers or licensing agencies may still deny jobs or licenses if an individual's prior conviction was "directly job-related" to the specific license sought or if the issuance of the license would create a threat to people or property. *See* Legal Action Center, *Setting the Record Straight* 9 (2001), *available at* http://hirenetwork.org/pdfs/setting_the_record_straight.pdf; Jennifer Leavitt, *Walking a Tightrope: Balancing Competing Public Interests in the Employment of Criminal Offenders*, 34 CONN. L. REV. 1281, 1294 (2002) (discussing the New York statutory scheme addressing employment discrimination for applicants with criminal histories, in which the legislature has included criminal history as one of the prohibited bases of discrimination in its general Human Rights Law, along with race, religion, creed, sex, and others, and stressing that "private and public employers are forbidden from denying licenses or employment 'to any individual by reason of his or her having been convicted of one or more criminal offenses,' and all employers are barred from inquiring about, or acting adversely upon, information regarding arrests that terminated in favor of the accused"); Love, *supra* note 26, at 6 ("Thirty-three states have laws on their books that purport to limit consideration of conviction in connection with employment and/or licensing decisions, requiring that the offense of conviction be 'substantially' or 'directly' related to the license and/or employment sought."). However, many states reserve exceptions to such prohibitions and generally do not maintain enforcement mechanisms. *See also* Seth Barnett, *Negligent Retention: Does the Imposition of Liability on Employers for Employee Violence Contradict the Public Policy of Providing Ex-felons with Employment Opportunities?,* 37 SUFFOLK U. L. REV. 1067, 1080 (2004) (discussing the New York statutory scheme that allows employers to consider conviction records under certain, limited circumstances, and which allows for the denial of employment if the hire would create unreasonable risks—stressing the significance of the direct relationship between the prior conviction and the type of employment being sought).

50 *See* August S. Downing, *New York Inspection: Registration of Professional Schools by the Board of Regents of the University of the State of New York*, 26 AM. J. NURSING 105 (1926) (In 1889, the Board of Regents of The University of the State of New York was charged with the power to grant medical licenses.). Physicians must be twenty-one years of age (waived for those who are at least eighteen and in a residency program until age twenty-one) a citizen or legal

("OPMC"),[51] a special division of the Department of Health that includes 102 doctors on a 159-member board.[52] OPMC investigates complaints, oversees probations of physicians, physician assistants, and specialist assistants, and serves as a staff for the Board for Professional Medical Conduct ("BPMC"), the group responsible for actually adjudicating cases. At the end of 2005, the BPMC was comprised of 142 physicians and 56 lay members, five of which were physician assistants. Board membership is appointed by the Commissioner of Health based on recommendations by medical and professional societies, with lay members being subject to approval by the governor.[53] Remedies and sanctions imposed within this administrative structure are in addition to those levied by the criminal and civil justice systems.[54]

III. Bad Medicine

Since state medical boards are authorized to regulate the profession for the public's general welfare in the form of standards of conduct (i.e. credentialing and licensing), such boards have been

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alien, of good moral character, must pay all fees, and must pass all required board examinations. N.Y. Educ. Law § 6524 (Consol. 2009).

51 *See* Kelton, *supra* note 5 ("OPMC's jurisdiction is separate and distinct from law enforcement prosecutorial agencies. Its mandate is to investigate allegations of misconduct and, where appropriate, impose sanctions on the physician's license to practice medicine.").

52 Andis Robeznieks, *Public Active on Medical Boards, not Always Tougher on Doctors*, 45 Am. Med. News 1–2 (Nov. 11, 2002), *available at* http://www.ama-assn.org/amednews/2002/11/11/prl11111.htm/.

53 *See* Kelton, *supra* note 5.

54 What constitutes "unprofessional conduct" is defined by the Board of Regents, applying to all professions, though each of the regulated professions maintains its own additional rules. The general terms include, but are not limited to: willfully making or filing false reports required by the Education Law; failing to release or to provide copies of records on request; releasing confidential information without authorization; performing professional services without authorization; engaging in false advertising; and exercising undue influence over patients or clients. *See* Paul Bennett Marrow, *Professional Misconduct: New York's Unified System for Professional Misconduct and Discipline*, 29 Westchester B.J. 15, 18 (2002), *available at* http://www.marrowlaw.com/UploadedDocuments/PROFESSIONALMISCONDUCT.doc. "Professional misconduct" is defined by §§ 6509 and 6509(a)–(c) of the Education Law and within the rules of the Board of Regents. Behavior that may constitute professional misconduct, applicable to all regulated professions, includes fraudulently obtaining a license; practicing any profession fraudulently, beyond its scope, with gross incompetence, with gross negligence on a particular occasion, or with negligence or incompetence on more than one occasion; practicing under the influence of alcohol or drugs or while physically or mentally impaired; or being convicted of a crime under the laws of the state of New York or any other state (where the act would constitute a crime in New York) or federal law. *See id*. at 17.

given broad discretion by courts.[55] Options available to a board might include: (a) additional training or education; (b) some manner of service to the community or profession; (c) probationary supervision; (d) license suspension; and/or (e) license revocation.[56] When discipline *is* instituted by either hospital peer review committees or state medical boards, federal law requires that the measures taken be reported to the National Practitioner Data Bank,[57] although other private organizations also act as a kind of clearinghouse for such information.[58] According to a 1999 Institute of Medicine report, those typically sanctioned are health care professionals who "may be incompetent, impaired, uncaring, or may even have criminal intent" and thus were properly the subject of investigation and/or action in order to protect patients from harm.[59] On a national scale, one study shows that disciplinary actions were imposed upon only about .05% of all physicians in the United States or approximately 4,000 of the 800,000 licensed physicians practicing in the U.S. in 2000.[60] That said, other studies have gleaned significant correlations between increased disciplinary action rates and specific medical specialties,[61] the age of the physician,[62] de-

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55 *See In re* License Issue to Zahl, 186 N.J. 341 (2006).

56 *See* S. Sandy Sanbar & Daniel Gamino, *Medical Practice: Education and Licensure*, *in* AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE 83 (6th ed. 2004); FEDERATION OF STATE MEDICAL BOARDS, *supra* note 48. Some states require that a physician's license may only be revoked if its decision meets the standard of "clear and convincing" evidence, a threshold meant to recognize the physician's license as a property interest warranting due process protections, although the majority of states require licensing boards to meet a lesser standard—"preponderance of the evidence"—on the assumption that public safety outweighs individual property claims. *See generally* William P. Gunnar, M.D., *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?*, 14 ANNALS HEALTH L. 329, 337–39 (2005); Widmer, *supra* note 38, *passim*.

57 42 U.S.C. §§ 11132–11133 (2006).

58 *See* PUBLIC CITIZEN, HEALTH RESEARCH GROUP, RANKINGS OF STATE MEDICAL BOARD SERIOUS DISCIPLINARY ACTIONS: 2003–2005 (2006), http://www.citizen.org/publications/release.cfm?ID=7428.

59 *See* TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 169 (Linda T. Kohn et al. eds., 2000).

60 *See* FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC., SUMMARY OF 2001 BOARD ACTIONS 17 (2002), *available at* http://www.fsmb.org/pdf/FPDC_Summary_BoardActions_2001.pdf.

61 *See* Neal D. Kohatsu et al., *Characteristics Associated with Physician Discipline*, 164 ARCHIVES INTERNAL MED. 653, 656 (2004) (studying 890 physicians disciplined by the Medical Board of California from 1998–2001 and finding an association between various physician characteristics and the likelihood of medical board-imposed discipline, and observing in particular that obstetrics and gynecology, general practice, psychiatry, and family practice were considered specialists more likely to be disciplined than other specialties).

grees from an international medical school,[63] and evidence of prior unprofessional behavior in medical school.[64]

A. Complaints

Mandated by law to investigate each complaint that comes in, the New York State OPMC receives approximately 7,000 actions per year.[65] Complaints come from a variety of sources, including patients, state government, other states, insurers, prosecutors, physicians themselves, and other sources such as medical administrative staffs, other doctors, and the media. Complaints must come to OPMC in written form, detailing the physician's information and information about the incident.[66] To ensure legitimacy, OPMC does not accept e-mails or faxes. The office also monitors actions taken by other states to determine what, if any, infractions have been brought against physicians outside New York.[67] Referrals might also come from courts, from the newspaper, or from the Federation of State Medical Boards ("FSMB"). We will discuss how imperfect the first two mechanisms are later, but FSMB maintains that all sister-state actions are reported to each state's medical board; thus, any infraction reported to an out of state medical

62 *See id.* (finding a positive association between age and discipline, meaning that physicians in practice for longer than twenty years were more likely to have been disciplined, but conceding that it is unclear whether this is due to an increased amount of time spent in practice or diminishing knowledge and skills that may correlate with the aging process). *See also* James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1891 (1998) (finding that physicians in practice for more than twenty years were more likely to be disciplined); Christine E. Dehlendorf & Sidney M. Wolfe, *Physicians Disciplined for Sex-Related Offenses*, 279 JAMA 1883, 1887 (1998) (finding that, of those physicians disciplined for sex-related offenses, 58.1% were between 45–64 years of age, while nationally only 34.5% of physicians are in that category).

63 *See* Kohatsu, *supra* note 61, at 656 (finding that international medical graduates were "significantly more likely to be disciplined than domestic graduates . . . .").

64 *See* Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 NEW ENG. J. MED. 2673, 2676 (2005) (studying 235 graduates, coming from three medical schools, who were disciplined by one of forty state medical boards between 1990 and 2003, and finding that disciplinary action by state boards was strongly associated with prior unprofessional behavior in medical school).

65 *See* 2005 MEDICAL CONDUCT ANNUAL REPORT, *available at* http://www.health.state.ny.us/professionals/doctors/conduct/annual_reports/2005/docs/2005_annual_report.pdf. The process section draws heavily from this report.

66 *See* OFFICE OF PROFESSIONAL MEDICAL CONDUCT, HOW TO CHOOSE THE RIGHT PHYSICIAN, http://www.health.state.ny.us/nysdoh/opmc/howto2.htm (last visited Oct. 11, 2008).

67 Telephone Interview with New York state official, Office of Professional Medical Conduct (May 18, 2007) [hereinafter "Interview #10"].

board *should* reach the New York State OPMC, even if infractions from within the state do not.

Each complaint is initially reviewed by OPMC's medical and investigatory staff. Any criminal conviction constitutes *prima facie* evidence of misconduct and, by law, BPMC must take action. Without a conviction, but with evidence of possible misconduct, a complaint is assigned to one of the office's investigators who will contact the physician, through mail or by phone, to request records of the incident and to conduct an interview. Interviews are also conducted, usually via phone, with the complainant and relevant witnesses. Those short of misconduct number only a few hundred of the approximately 7,000 per year, and these are dismissed before being assigned to an investigator. At this point, the case can go in any of three directions. First, if the evidence is insufficient, the case may be dismissed. Second, if the case is outside the jurisdiction of OPMC, it is referred to a more appropriate office. This might occur if cases have to do with other medical professionals outside of OPMC's jurisdiction, such as nurses; if the complaint has to do with insurance disputes; or if the complaint should be handled internally within the hospital from which it originated. Third, if there is sufficient evidence of misconduct, the investigator presents the complaint to an investigatory committee.[68]

The investigatory committee is a three person committee, made up of two physicians and one lay person, drawn from BPMC, which consists of about 200 members.[69] The investigating committee, the Director of OPMC, and the Executive Secretary to BPMC review the evidence and the Director, in consultation with the Executive Secretary, makes a recommendation to the committee for a dismissal, a warning, a consultation, or for charges.[70] The committee reserves veto power and if it exercises this authority, the Director may consult with the staff attorneys who filed the charge and may change or increase the number of charges on the table. There is no statutory limit on how many times the Director may resubmit

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[68] Interview with defense attorney in New York, N.Y. (Jan. 8, 2008) [hereinafter Interview #5].

[69] Interview with defense attorney in New York, N.Y. (Aug. 29, 2007) [hereinafter Interview #2].

[70] A warning or consultation will occur when the complaint is of a minor or technical nature that does not constitute professional misconduct. Administrative warnings are issued by the Director, who will also choose a panel of experts to commence in a consultation with the charged physician. These warnings and consultations are kept confidential. A record of all investigations and complaints undertaken or received by OPMC is retained to follow up on further problems or complaints with a particular physician or practice, but is not kept in the public domain.

recommendations to the committee. If the investigating committee decides to file charges, a notice of hearing and a statement of charges will be prepared by a staff attorney employed by the Department of Health. This same attorney usually brings charges in the BPMC hearing. The committee may also recommend to the Commissioner of Health that the physician be summarily suspended due to some imminent danger to the public and this discretion extends as long as the investigatory committee determines that such danger exists.

Physicians and BPMC also frequently agree to postpone cases. This can be done for several reasons. A physician and his or her attorney may want to concentrate on the criminal court case first, or a physician may simply not be ready to respond to the charges within the ten-day window opened upon the filing of OPMC's brief. By agreeing to a summary order, the physician can generate more time for the filing of papers and can also convince the OPMC attorney—out of court—to reduce the initial charges. Indeed, some respondents indicated to us that it was advantageous to the physician to contest the criminal case first, since if he succeeded in an acquittal in that arena it would *not* summarily lead to an OPMC conviction, due to the higher standard of proof employed for criminal matters.[71]

B. Adjudication

About 350 of the roughly 7,000 annual complaints result in a disciplinary hearing each year. The hearing functions like a trial, with the three person investigatory committee (two physicians and one layperson) acting as a jury that may also ask questions. An administrative judge is on hand to govern the proceedings and answer legal questions. A health department attorney presents OPMC's case and the physician is usually represented by his own attorney. Evidence may be presented and witnesses, including the complainant, may be called on both sides. The committee then has sixty days from the last hearing day to confer and decide which charges will be sustained.[72]

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[71] Interview with defense attorney in New York, N.Y. (Aug. 22, 2007) [hereinafter Interview #1]; Interview with New York state official, Office of Professional Medical Conduct, in New York, N.Y. (Jan. 8, 2008) [hereinafter Interview #6].

[72] *See* 2005 MEDICAL CONDUCT ANNUAL REPORT, *supra* note 65.

Following a ruling, physician respondents may appeal to the Appellate Division, Third Department, one of the intermediate courts in New York. This Albany-based court deals with district court appeals and appeals of decisions from state agencies, known as "Article 78" challenges.[73] With limited review powers, this court can lower but cannot substitute penalties, although it can remand cases that "shock the conscience" and even offer an opinion of the penalty that it would accept.[74] Moreover, both sides of the case may appeal the decision to the Administrative Review Board ("ARB"), also composed of three members of BPMC.[75] A physician may first commence an Article 78 proceeding, followed by a request for administrative review, but following the decision in *Rudell v. Commissioner of Health*,[76] she is at a disadvantage if she works the other way around because a physician who "believes that a Committee determination can be challenged because of the insufficiency of the evidence presented at the hearing, will lose the right to raise such an argument in court by first invoking administrative review."[77] ARB is designed to be a leveling mechanism, in theory, because it is the same five people who serve for three year terms, so they can review the panel judgments and impose penalties. Indeed, respondents indicated that ARB is "notoriously difficult" and a "waste of time and money" because it mostly adhered to or increased penalties.[78]

Physicians given probation are monitored by officers contracted by OPMC. This usually involves "boiler plate" conditions, as one respondent described them to us,[79] which the physician must adhere to or risk being reported to OPMC and being charged with further infractions. This would also occur for suspended physicians

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73 *See* Michael S. Kelton, *Two Options for Review of Professional Medical Conduct Hearings*, NEWS OF NEW YORK, *available at* http://www.keltonlawfirm.com/pdf/Kelton_Medical_Conduct_Hearings.pdf.

74 Interview #6, *supra* note 71; Interview with New York state official, Office of Professional Medical Conduct, in New York, N.Y. (Sept. 2, 2008) [hereinafter Interview #8].

75 As indicated in our interviews and OPMC official releases, this is a standing committee. If there is an appeal, each side has time to file briefs and then time to file responses to these briefs. In the meantime, revocations, suspensions, and surrenders are not stayed, but all other punishments are. These other punishments are also not made public during the appeals process. Appeals have no hearings or testimony; the ARB simply issues a written determination. If there was no hearing, there can be no ARB appeal because this constitutes consent. Kelton, *supra* note 73.

76 *See* Kelton, *supra* note 73 (citing Rudell v. Comm'r of Health, 604 N.Y.S.2d 646, 647 (N.Y. App. Div. 3d Dept. 1993)).

77 *Id.*

78 Interview #5, *supra* note 68.

79 Interview #2, *supra* note 69.

that OPMC discovered were practicing again. If a physician is suspended for a definite time, punishment expires automatically, and a physician continues normal practice. If a physician is indefinitely suspended, however, a hearing must be held in front of BPMC to confirm that a physician has met the conditions originally set out for him or her.

Those physicians who have their licenses revoked must reapply through DOE, as licensing is controlled by DOE, and ultimately the state Board of Regents, which confers all licenses in the state of New York.[80] A physician may not reapply for a license within three years of losing it due to revocation or surrender. At this time, a physician may submit a reapplication to the Committee on Professions. Committee staff members collect information about the application, including relevant mandatory and voluntary reeducation efforts, evidence of rehabilitation, work experiences, and references from other physicians. This information is forwarded to an investigation unit at DOE's Office of Professional Discipline, which verifies this information and interviews the respondent. They also send a copy of the application to OPMC, which issues a letter of recommendation for or against the physician. This is forwarded to the DOE prosecutor, who presents the case in front of a hearing panel that consists of three physicians from the State Board of Medicine, part of DOE's Office of Professions, as well as an administrative judge. After this evidentiary hearing, the panel makes a recommendation to the Committee on Professions.[81] The Committee, a set of senior administrators and managers within the Office on Professions, issues another recommendation to the Board of Regents, and the Board determines, in light of these two recommendations, whether a physician may regain his or her license.[82]

80 Telephone Interview with New York state official, Department of Education (Oct. 22, 2008) [hereinafter Interview #9].

81 While it would surely be revealing to have access to this information, we were told that these meetings would no longer be transcribed because of budget cuts.

82 Physicians applying for the first time do not normally go through this process, unless there is a moral character question, such as a previous felony. In this case they also must be vetted by the two panels.

IV. Evidence

A. Methodology

In assembling subjects for our extended interviews, we first located some of the key figures in this relatively small universe and then utilized the "snowball" technique of respondent-recruitment.[83] This method, especially well-suited for studies involving networks of professionally-connected respondents who tend to be the "major players" within an arena,[84] yielded ten interviews, averaging about two and one-half hours in length (with eight different individuals and two follow-ups)—eight of which were conducted in person and two by phone. Each of the interviews was conducted by two of the authors, with one primarily responsible for note-taking and the other charged with posing questions during the process. Following each gathering, both researchers would meet for several hours and compare recollections and written notes as a means of preserving accurate assessments of the subjects' responses. All of the respondents were promised anonymity, and to preserve this, we have changed and obscured descriptive characteristics and have assigned numbers to each interview for purposes of citation and correlation.

Beyond the information gleaned from the interviews, we have collected what is to our knowledge the most extensive time-series

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83 *See* Heumann et al., *supra* note 10, at 29–30 (2005); Jean Schensul et al., Enhanced Ethnographic Methods 72 (1999).

84 Interviews were conducted with individuals who had worked on both sides of the disciplinary process, including two subjects who worked exclusively on prosecution, two who attended exclusively to defense matters, one individual associated with the Committee on Physician Health, a private rehabilitation service loosely affiliated with the state and contracted with the New York Medical Association, and another associated with the Federation of State Medical Boards, an organization that communicates disciplinary records between different state medical boards. Moreover, while examining the quantitative data, we discovered that the attorneys we had interviewed had frequently represented both respondents and petitioners on both sides of the process.

We should stress here that our preliminary investigation of these questions makes it clear that subsequent studies should include interviews not only with additional attorneys on both sides of the dispute, but also with incumbents of other related positions. Two possibilities in particular would be quite significant. First, interviews should be conducted with insurance officials who, among other things, appear to have a gatekeeper role in terms of reporting or not reporting some kinds of physician behavior to OPMC. Second, interviews ought to be conducted with the physicians themselves to explore firsthand the consequences of felony convictions for their medical licenses.

data set on the disciplinary process for offending physicians.[85] Our coding was based upon the case summaries reported by OPMC on its website, which summarized all acts of physician misconduct since 1990,[86] but which often failed to note whether or not the conviction was for a felony offense.[87] And thus, we were forced to make assumptions ourselves about the facts that separated felony and non-felony professional offenses. Coding of records attended to two critical features of each case: the punishment(s) received and the underlying infraction(s). Punishments were coded in an ascending order of severity: beginning with *no punishment*, followed by *unknown/other*, *censure*, *fine*, *conditions*, *probation less than three years*, *probation greater than three years*, *suspension less than one year*, *suspension greater than one year*, *indefinite suspension*, *clinical limitation*, *surrender*, and *revocation*.[88] Further notes on our coding scheme can be found in the Appendix.

Infractions were more difficult to code for a few reasons. In order of increasing seriousness, our categories were: *none*, *unknown/other*, *professional*, *psychiatric*, *prescription of controlled dangerous substances (CDS)*, *sexual offenses*, *drug use*, *violence*, *fraudulent practice*, *insurance fraud*, and *other* felonies. We distinguished between non-felonies and felonies with respect to psychiatric offenses and controlled substance offenses, with psychiatric offenses falling within the non-felony category and controlled substances falling within the felony category. Controlled substance infractions did sometimes occur simply because physicians were prescribing drugs inappropriately, but in the vast majority of cases they involved the prescription of drugs for recreational use or sale to patients. We should note, too, that sex cases were all coded as

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[85] Annual data were obtained from the New York Health Department Office of Professional Misconduct, http://w3.health.state.ny.us/opmc/factions.nsf (Nov. 16, 2009). New York was the first state to list its disciplinary actions against licensed physicians on the internet in this way. *See* Press Release, Office of Professional Misconduct, New York's Doctor Discipline Reports Are Now on the Internet (July 30, 1996), *available at* http://www.health.state.ny.us/press/releases/1996/docweb.htm. Our data includes 4,739 cases, 2,163 of which were for felony offenders.

[86] *See* OPMC, *supra* note 85. We have some questions about the completeness of data from before 1990 and thus have not included these data in our set.

[87] Although full hearing records were available, resource constraints limited our analysis to these summaries. Nonetheless, we are confident about our data because OPMC case summaries generally provide adequate information and because we randomly sampled a set of the fuller records and tested these against the inferences we drew from the case summaries. In almost every instance, our inferences proved to be accurate.

[88] We note here that OPMC used the punishment, "stayed suspension," quite frequently, which resulted in a probation for that length of time with a suspension to be activated if a physician exhibited further misconduct.

felonies even though they might have involved sexual relations with staff members or consensual sex—an issue we will explore in further depth later. It is also important to note here that, because many physicians are licensed in multiple states, the data include numerous cases in which the original offense was committed in a state other than New York. All cases coded as "sister-state actions" were referred to the New York OPMC from other state medical boards, which in turn receive similar reciprocal notification from New York. And thus, disciplinary action by other states is included in our data and represents 2,030, or 42.8%, of our cases.[89]

B. Results

While our primary interest is the collateral consequences of *felonies* in New York and specifically the implications for physician licensing, it is instructive to consider as well non-felony offenses and those infractions arising in sister-states. And, thus, we begin our analysis with Table 1, which includes both felonies *and* non-felonies for New York *and* sister-states. Within the eighteen year time span, certain phenomena warrant some attention. Of the 4,739 cases considered within this period, slightly more than half overall (54.4%) were *non*-felony cases. Indeed, non-felony cases were a greater percentage of cases for fifteen of the eighteen years considered; the highest percentage for any individual year (of those fifteen) was 61.7%. Additionally, we can see here a significant spike in the total number of cases during the early-to-mid 1990's, rising from 113 in 1992 to 302 in 1995. Within this period, "professional" non-felony cases saw more than a 100% increase, climbing from sixty in 1992 to 127 in 1995; "sex"-related felony cases increased almost four-fold (from eleven in 1992 to forty-one in 1995); and "drug"-related felony cases increased nearly seven-fold (from

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[89] Collectively, these qualitative and quantitative data combine to allow us to confidently conduct an exploratory study of the felony disciplinary process in New York, one that, nonetheless, does rest on a solid empirical base. Indeed, the respondents themselves were eager to learn about our data, since they had little opportunity to enjoy a broad and varied perspective of the system. They were uncertain about the patterns we would find, curious about what the quantitative data would reveal about the "bigger picture" of sanctioning for criminal offenses (although we were careful to conceal these data until after interviews had been conducted), and frequently had either at most a vague sense of the bigger picture or a misleading sense of what constituted the bigger picture. For example, the different respondents had different characterizations of the worst crime. In this kind of matter, the quantitative data, even in a rough form, can illuminate N.Y. state practices. See the results section for further discussion.

four in 1992 to twenty-seven in 1995). Although we can only speculate, this could reflect an increase in resources, an internal policy change, or a reporting change.

Moving to Table 2, which contains data for both felony and non-felony offenses arising in New York (as opposed to other states), we see that, consistent with the global totals in Table 1, slightly more than half of all cases (54.6%) involved *non*-felony offenses. But unlike what we observed for the period 1992–1995 in the previous table, with respect to "professional" non-felony offenses during this time, we cannot locate the same marked upsurge in the data pertaining only to New York State.[90] There is, to be sure, an escalation during these years, but for this particular category the increase is modest by comparison—going from forty-eight (in 1992) to sixty-seven (in 1995).

Where we do see a pattern similar to that portrayed in Table 1, however, is with respect to "sex" felony cases, as sex-related crimes increased from eight (in 1992—and as late as 1994) to twenty (in 1995). Our interviews with officials and attorneys working on these issues suggest an interesting explanation for this phenomenon. In 1995, the Department of Health issued an order to OPMC to adopt a "zero tolerance" policy towards sex crimes, and it is our sense that the increase in prosecution of sex related offenses was a direct reflection of this policy.[91] But these criminal sexual conduct data also afford us an opportunity to appreciate the variance within categories.[92] Indeed, while there was increased sanctioning of sex offenses in 1995, one can infer from Table 3 below (connecting punishments to their underlying felony offenses) that the approach to sex crimes was hardly "zero tolerance," if that implies that one's license is revoked upon conviction. Multiple interviewees shed

[90] We do note, however, some interesting fluctuations in this category during other periods within the eighteen year span. From 1996–1997, for example, the number increased from seventy-five to 106; from 2000–2001 the number dropped from 103 to seventy-one; and from 2005–2006 the number dropped again from seventy-eight to forty-one.

[91] An interesting corollary point is that there is a New York statute that makes any sex, even consensual, in a doctor's office or hospital, a crime. N.Y. PENAL LAW § 130.05 (Consol. 2009). Even if pled down to a misdemeanor, one could be listed as a first degree sexual offender for the next ten years, during which one could not regain a license from the Department of Education.

[92] We also see a rise of CDS cases from 1994 to 1996, which might indicate a "get-tough strategy" that coincides with the 1995 edict. This is further complicated because none of the other felony categories see this same jump. However, CDS and sex offenses are both offenses unique to the experience of physicians, who have special access to controlled dangerous substances and a unique power relationship with patients. This again suggests a 1995 change of philosophy in BPMC as regarding the necessity of punishing physicians uniquely for their circumstances.

TABLE 1: FELONY & NON-FELONY OFFENSES (NEW YORK + SISTER-STATES)

	1990		**1991**		**1992**		**1993**		**1994**		**1995**		**1996**		**1997**		**1998**		**1999**	
Non-Felonies																				
None	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.5%
Unknown/Other	3	7.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.6%	0	0.0%	1	0.5%
Professional	36	85.7%	39	95.1%	60	96.8%	90	94.7%	101	92.7%	127	90.7%	132	90.4%	161	95.3%	172	97.2%	171	94.0%
Psychological	3	7.1%	2	4.9%	2	3.2%	5	5.3%	8	7.3%	13	9.3%	14	9.6%	7	4.1%	5	2.8%	9	4.9%
Sub-total	42	40.8%	41	52.6%	62	54.9%	95	51.6%	109	48.0%	140	46.4%	146	50.5%	169	56.0%	177	61.2%	182	61.7%
Felonies																				
CDS	14	23.0%	8	21.6%	12	23.5%	21	23.6%	38	32.2%	41	25.3%	38	26.6%	23	17.3%	17	15.2%	13	11.5%
Sex	9	14.8%	8	21.6%	11	21.6%	20	22.5%	21	17.8%	41	25.3%	35	24.5%	29	21.8%	25	22.3%	21	18.6%
Drugs	9	14.8%	1	2.7%	4	7.8%	7	7.9%	18	15.3%	27	16.7%	38	26.6%	37	27.8%	23	20.5%	24	21.2%
Violence	6	9.8%	3	8.1%	1	2.0%	7	7.9%	6	5.1%	3	1.9%	1	0.7%	5	3.8%	3	2.7%	1	0.9%
Fraud	12	19.7%	1	2.7%	1	2.0%	2	2.2%	1	0.8%	5	3.1%	2	1.4%	2	1.5%	2	1.8%	17	15.0%
Ins Fraud	6	9.8%	12	32.4%	17	33.3%	21	23.6%	22	18.6%	23	14.2%	21	14.7%	20	15.0%	26	23.2%	25	22.1%
Other	5	8.2%	4	10.8%	5	9.8%	11	12.4%	12	10.2%	22	13.6%	8	5.6%	17	12.8%	16	14.3%	12	10.6%
Sub-total	**61**	**59.2%**	**37**	**47.4%**	**51**	**45.1%**	**89**	**48.4%**	**118**	**52.0%**	**162**	**53.6%**	**143**	**49.5%**	**133**	**44.0%**	**112**	**38.8%**	**113**	**38.3%**
TOTAL	**103**		**78**		**113**		**184**		**227**		**302**		**289**		**302**		**289**		**295**	

TABLE 1 (CONTINUED)

	2000		2001		2002		2003		2004		2005		2006		2007		TOTAL			
Non-Felonies																				
None	3	1.5%	2	1.3%	2	1.2%	1	0.6%	1	0.6%	0	0.0%	1	0.5%	3	1.9%	14	0.5%		
Unknown/Other	0	0.0%	0	0.0%	1	0.6%	1	0.6%	9	5.0%	22	11.4%	25	12.5%	18	11.3%	81	3.1%		
Professional	181	91.4%	149	94.3%	148	91.4%	157	96.3%	158	88.3%	163	84.5%	170	85.0%	132	82.5%	2347	91.1%		
Psychological	14	7.1%	7	4.4%	11	6.8%	4	2.5%	11	6.1%	8	4.1%	4	2.0%	7	4.4%	134	5.2%		
Sub-total	198	59.6%	158	51.6%	162	56.4%	163	50.2%	179	53.6%	193	57.4%	200	60.2%	160	52.5%	2576	54.4%		
Felonies																				
CDS	15	11.2%	21	14.2%	13	10.4%	25	15.4%	25	16.1%	18	12.6%	29	22.0%	25	17.2%	396	18.3%		
Sex	32	23.9%	30	20.3%	20	16.0%	24	14.8%	34	21.9%	14	9.8%	19	14.4%	25	17.2%	418	19.3%		
Drugs	35	26.1%	28	18.9%	38	30.4%	43	26.5%	49	31.6%	55	38.5%	34	25.8%	44	30.3%	514	23.8%		
Violence	5	3.7%	5	3.4%	2	1.6%	5	3.1%	3	1.9%	3	2.1%	3	2.3%	5	3.4%	67	3.1%		
Fraud	11	8.2%	27	18.2%	21	16.8%	24	14.8%	12	7.7%	27	18.9%	22	16.7%	21	14.5%	210	9.7%		
Ins Fraud	22	16.4%	18	12.2%	20	16.0%	25	15.4%	15	9.7%	13	9.1%	18	13.6%	19	13.1%	343	15.9%		
Other	14	10.4%	19	12.8%	11	8.8%	16	9.9%	17	11.0%	13	9.1%	7	5.3%	6	4.1%	215	9.9%		
Sub-total	134	40.4%	148	48.4%	125	43.6%	162	49.8%	155	46.4%	143	42.6%	132	39.8%	145	47.5%	2163	45.6%		
TOTAL	332		306		287		325		334		336		332		305		4739			

TABLE 2: FELONY & NON-FELONY OFFENSES (NEW YORK)

	1990		**1991**		**1992**		**1993**		**1994**		**1995**		**1996**		**1997**		**1998**		**1999**	
Non-Felonies																				
None	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Unknown/Other	3	7.5%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.9%	0	0.0%	1	0.9%
Professional	34	85.0%	34	94.4%	48	96.0%	63	96.9%	59	98.3%	67	93.1%	75	91.5%	106	96.4%	123	99.2%	110	94.0%
Psychological	3	7.5%	2	5.6%	2	4.0%	2	3.1%	1	1.7%	5	6.9%	7	8.5%	3	2.7%	1	0.8%	6	5.1%
Sub-total	**40**	**44.4%**	**36**	**52.9%**	**50**	**57.5%**	**65**	**53.7%**	**60**	**55.0%**	**72**	**49.3%**	**82**	**61.2%**	**110**	**64.3%**	**124**	**66.7%**	**117**	**65.7%**
Felonies																				
CDS	9	18.0%	5	15.6%	9	24.3%	8	14.3%	10	20.4%	13	17.6%	11	21.2%	5	8.2%	4	6.5%	2	3.3%
Sex	6	12.0%	7	21.9%	8	21.6%	10	17.9%	8	16.3%	20	27.0%	17	32.7%	16	26.2%	11	17.7%	9	14.8%
Drugs	9	18.0%	1	3.1%	1	2.7%	6	10.7%	7	14.3%	8	10.8%	10	19.2%	12	19.7%	13	21.0%	8	13.1%
Violence	6	12.0%	3	9.4%	1	2.7%	5	8.9%	3	6.1%	2	2.7%	0	0.0%	1	1.6%	3	4.8%	0	0.0%
Fraud	9	18.0%	1	3.1%	0	0.0%	0	0.0%	1	2.0%	2	2.7%	0	0.0%	2	3.3%	0	0.0%	13	21.3%
Ins Fraud	6	12.0%	11	34.4%	15	40.5%	18	32.1%	11	22.4%	13	17.6%	7	13.5%	15	24.6%	19	30.6%	20	32.8%
Other	5	10.0%	4	12.5%	3	8.1%	9	16.1%	9	18.4%	16	21.6%	7	13.5%	10	16.4%	12	19.4%	9	14.8%
Sub-total	50	55.6%	32	47.1%	37	42.5%	56	46.3%	49	45.0%	74	50.7%	52	38.8%	61	35.7%	62	33.3%	61	34.3%
TOTAL	**90**		**68**		**87**		**121**		**109**		**146**		**134**		**171**		**186**		**178**	

TABLE 2 (CONTINUED)

	2000		2001		2002		2003		2004		2005		2006		2007		TOTAL			
Non-Felonies																				
None	3	2.7%	1	1.3%	2	2.2%	1	1.0%	1	0.9%	0	0.0%	1	1.8%	3	3.7%	12	0.8%		
Unknown/Other	0	0.0%	0	0.0%	1	1.1%	1	1.0%	8	7.1%	18	18.2%	12	21.8%	17	20.7%	62	4.2%		
Professional	103	93.6%	71	94.7%	83	93.3%	97	95.1%	99	88.4%	78	78.8%	41	74.5%	59	72.0%	1350	91.2%		
Psychological	4	3.6%	3	4.0%	3	3.4%	3	2.9%	4	3.6%	3	3.0%	1	1.8%	3	3.7%	56	3.8%		
Sub-total	110	54.5%	75	47.2%	89	53.9%	102	47.7%	112	54.4%	99	51.6%	55	47.0%	82	49.7%	1480	54.6%		
Felonies																				
CDS	8	8.7%	5	6.0%	0	0.0%	9	8.0%	8	8.5%	1	1.1%	2	3.2%	7	8.4%	116	9.4%		
Sex	19	20.7%	18	21.4%	14	18.4%	18	16.1%	20	21.3%	9	9.7%	9	14.5%	12	14.5%	231	18.8%		
Drugs	21	22.8%	10	11.9%	17	22.4%	24	21.4%	31	33.0%	39	41.9%	20	32.3%	31	37.3%	268	21.8%		
Violence	3	3.3%	3	3.6%	2	2.6%	5	4.5%	3	3.2%	3	3.2%	1	1.6%	4	4.8%	48	3.9%		
Fraud	9	9.8%	21	25.0%	15	19.7%	22	19.6%	7	7.4%	20	21.5%	12	19.4%	15	18.1%	149	12.1%		
Ins Fraud	20	21.7%	16	19.0%	18	23.7%	20	17.9%	12	12.8%	8	8.6%	12	19.4%	9	10.8%	250	20.3%		
Other Felony	12	13.0%	11	13.1%	10	13.2%	14	12.5%	13	13.8%	13	14.0%	6	9.7%	5	6.0%	168	13.7%		
Sub-total	**92**	**45.5%**	**84**	**52.8%**	**76**	**46.1%**	**112**	**52.3%**	**94**	**45.6%**	**93**	**48.4%**	**62**	**53.0%**	**83**	**50.3%**	**1230**	**45.4%**		
TOTAL		**202**		**159**		**165**		**214**		**206**		**192**		**117**		**165**		**2710**		

light on this disconnect between the stated policy and the punitive practices. As one respondent put it, OPMC policy is "a ridiculous position" and "all the actors concerned with [it] know that it is ridiculous and do not follow it."[93]

One thing that perhaps made the policy seem "ridiculous" was the perceived need for *degrees* of "tolerance" and the importance of distinctions between varieties of sexual behavior. Indeed, our interviewees stressed that—in practice, at least—cases of consensual sex with *staff members* were usually treated in a more lenient manner,[94] though consensual sex with *patients* was a different, more precarious matter. Cases of consensual sex with patients were treated more leniently than surreptitious touching and other forms of psychologically coercive sexual activity, to be sure, but the line between coercive and non-coercive encounters was very blurry. Especially in the case of psychiatrists, who have the potential to exercise great coercion over their patients, consensual sex could be punished with permanent revocation; indeed, even physicians in other fields engaging in consensual acts could be indefinitely suspended.[95] In those cases when consensual sex led to a more lenient disposition, we were given the scenario that "a doctor thinks they're in love [with a patient or employee]."[96] "Then, she asks him to leave his wife," the story would go and he would say "no," and then "she reports him when it goes wrong."[97] This variation in perceived seriousness of sexual offenses is, we believe, what accounts for the variation in OPMC punishments discussed below. This observation underscores the more general notion that the more the offense is construed, or could be construed, as "unrelated" to the practice of medicine (e.g. a relationship with a subordinate), the better the offender's chances are at keeping his or her license.[98]

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93 Interview #2, *supra* note 69.

94 *Id.*

95 When told by an interviewee of one such case of oral sex between a patient and her physician, we inquired about what might be construed as draconian consequences for several minutes of consensual, albeit inappropriate, behavior, to which the attorney responded: "Several minutes? More like twenty seconds!" Interview #2, *supra* note 69.

96 *Id.*

97 *Id.*

98 In a refreshing twist on the general norms of our society, we note that multiple respondents indicated that for sexual conduct cases the BPMC is much more likely, on average, to believe the *female* (patient) than the *male* (physician). One reason for this is that the hearing group is sensitive to the fact that it is very difficult for the woman to bring these charges. Historically, it is commonly felt, that there was likely, in fact, some sexual abuse by physicians of patients, and despite this, it was very unusual for women to report this abuse. Respondents

Finally, we note the intriguing comparison between the distributions of felony offenses themselves within the two years that bookend our study. In 1990, the totals for various categories are remarkably balanced: there were nine "CDS," "Drugs," and "Fraud" cases, six "Sex," "Violence," and "Insurance Fraud" cases, and five cases categorized as "Others." By 2007, however, "Drugs" had gone from 18% to 37.3% and had become, after 2003, the most common type of felony case, overtaking insurance fraud in the end.[99] Other percentages adjusted accordingly, with "CDS" and "Violence" making the most dramatic drops as functions of the whole.

Turning to Table 3, we can see felony offense data condensed from all eighteen years for cases originating in New York State. This table organizes the punishments for each felony infraction into categories of similar severity.[100] If we collapse the first three classifications of punishment ("No Loss," "Monitoring," and "Temp Loss") and compare these three to the bottom two ("Indef Susp" and "Perm Loss"), we can examine the data contrasting permanent or infinite losses with those ascribed a defined duration of time.[101]

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suggest that the women were influenced by the aura that surrounded the physicians, one which made their words and activities seemingly unimpeachable. Respondents felt it was difficult to claim inappropriate physician behavior during an actual breast, pelvic, or other physical exam. Interview #5, *supra* note 68; Interview #6, *supra* note 71.

Here, we will spare readers the more graphic descriptions that respondents gave us. Indeed, it was frequently suggested that it would be wise for physicians to have chaperones present during physical exams, but this advice was rarely heeded. If a woman was not filing a civil suit, the BPMC seemed to give special credence to the woman's complaint. Indeed, defense attorneys said that physicians had a much better opportunity for an acquittal before juries who, all things being equal, seemed to defer to physicians more; the BPMC, on the other hand, was said, at least by one respondent, "to be more wise [sic] as to what is going on." Interview #5, *supra* note 68. In these instances, the burden of proof before the BPMC clearly shifted to the physician.

99 For an earlier point of reference on drug crimes and physician discipline, see DERBYSHIRE, *supra* note 43, at 78–79 (reporting on his earlier study, reviewing the FSMB files for the years 1963–67, and noting that the most common reason for disciplinary action was some type of violation of narcotics laws (46%), followed in a distant second by "mental incompetence" at about 10%, and "fraud and deceit in practice" at about 7.5%). Derbyshire's study is also extremely illuminating when one considers the effect of changing culture on the percentage of disciplinary actions that were sex cases.

100 "No loss" implies no punishment at all, but also includes sanctions such as fines and censures. "Monitoring" includes conditions and probations of any length. "Temporary Loss" (Temp Loss) includes suspensions of a defined length. "Indefinite Suspension" (Indef Susp) is a single punishment category. Finally, "Permanent Loss" (Perm Loss) is clinical limitation (a very severe sanction that effectively means a physician cannot practice his or her profession), surrender, and revocation.

101 On this distinction, see MILTON HEUMANN, PLEA BARGAINING (1977) (arguing that bargaining over "time" vs. "no time" in prison is a key plea bargaining variable). Bearing this in

TABLE 3: PUNISHMENTS & FELONY OFFENSES, 1990-2007 (NEW YORK)

Punishment	**CDS**		**Sex**		**Drugs**		**Violent**	
No Loss	11	9.5%	14	6.1%	23	8.6%	13	27.1%
Monitoring	46	39.7%	61	26.4%	84	31.3%	11	22.9%
Temp Loss	6	5.2%	12	5.2%	32	11.9%	0	0.0%
Indef Susp	2	1.7%	3	1.3%	28	10.4%	1	2.1%
Perm Loss	51	44.0%	141	61.0%	101	37.7%	23	47.9%
TOTAL	**116**		**231**		**268**		**48**	
Punishment	**Fraud**		**Ins Fraud**		**Other**		**Total**	
No Loss	8	5.4%	19	7.6%	44	26.3%	132	10.7%
Monitoring	50	33.6%	96	38.4%	55	32.9%	403	32.8%
Temp Loss	10	6.7%	8	3.2%	6	3.6%	74	6.0%
Indef Susp	3	2.0%	0	0.0%	5	3.0%	42	3.4%
Perm Loss	78	52.3%	127	50.8%	57	34.1%	578	47.0%
TOTAL	**149**		**250**		**167**		**1229**	

What we find here is that, including all crimes, it is about 50/50—that is, there is a 50.4% chance of losing one's license for an undefined period of time and a 49.6% chance of receiving some fixed sanction such as monitoring or a temporary loss. In the harsher category, most of the losses are formally "permanent," whereas in the less harsh category, most of the punishments are one form or another of monitoring for a physician who continues his practice. As we noted earlier about sex cases, one explanation for our 50/50 finding is that crimes within categories are not homogeneous, meaning that there really are not across-the-board sanctions, but rather considerable variation within categories of infraction.

When looking at cases of permanent loss, we note that sex-related offenses were most likely to lead to permanent deprivation of a physician's license. There were 141 sex-related felony offenses that led to permanent loss (61% of all sex cases), which is a figure that constitutes both the highest absolute number and the highest percentage of any offense leading to this permanent sanction. When physicians did *not* lose their licenses, we were struck by how often the court used a monitoring sanction that allowed physicians

mind is important here because defendants tend to view their options in similarly dichotomous terms: that is, having to serve time or not. Somewhat analogous to this, attorneys report that physicians clearly distinguish between an indefinite loss of license and all other sanctions and this distinction no doubt animates attorneys' bargaining at the licensing stage.

to continue practicing. In fact, in about one-third of all cases (32.8%), physicians were punished via monitoring, with Insurance Fraud mustering the greatest number of cases (ninety-six), but with CDS owning a slightly higher percentage of overall instances arriving at that sanction.[102] We also note from our full data set that there was some gradation on the length and conditions of probation and monitoring. Unfortunately, we did not collect data as to the particular conditions that a specific physician was required to meet to continue his or her practice, though some respondents indicated that they were "boiler plate conditions" or, in other words, "pay your fines, let us know if you move, [and] be good."[103] Respondents and in-depth examinations of disciplinary records indicated there were between ten and twelve of these often overlapping conditions, and many were usually given at once. Of course, the bottom line is that given this punishment, physicians are able to maintain their licenses.

We turn now to disciplinary actions originating outside of New York State. Table 4 includes the relationships between particular categories of felonies and associated punishments for New York and sister-states (i.e. reciprocal punishments). Note that the percentages are greater than those for only New York State (Table 3), but the ordering of offenses in terms of the likelihood that they led to permanent loss is about the same, with sex crimes generating the highest number of revocations (71.3%), followed by fraud (57.6%), insurance fraud (56.9%), and violent crimes (56.7%). Where the data from Table 4 do not track those from Table 3, however, is with respect to the percentages and ordering of offenses that lead to "Monitoring" as a punishment. Specifically, where "CDS" was the class of offense that most often necessitated monitoring in Table 3 (39.7%), it is ranked fifth according to the data in Table 4 (26.3%). Meanwhile, Insurance Fraud, which was second in Table 3 (38.4%), ranks first in Table 4 (33.5%).

Table 5 displays data regarding how New York State has treated individuals with felony records from *other* states. There are two things that stand out here: first, while New York ascribes monitoring as a punishment in 32.8% of cases involving felonies com-

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[102] For both offenses, however, it is interesting to see the bi-modal punishment determinations, where for CDS 39.7% of offenses end up with monitoring, but 44% end up with a permanent loss, and where for Insurance Fraud 38.4% end up with monitoring, but 50.8% lead to permanent loss. In other words, an offending physician who is guilty of one of those two offenses ends up either being monitored or having no license at all.

[103] Interview #2, *supra* note 69.

TABLE 4: PUNISHMENTS & FELONY OFFENSES, 1990-2007 (NEW YORK + SISTER-STATES)

Punishment	**CDS**		**Sex**		**Drugs**		**Violent**	
No Loss	55	13.9%	17	4.1%	25	4.9%	15	22.4%
Monitoring	104	26.3%	79	18.9%	137	26.7%	12	17.9%
Temp Loss	13	3.3%	17	4.1%	36	7.0%	0	0.0%
Indef Susp	8	2.0%	7	1.7%	59	11.5%	2	3.0%
Perm Loss	216	54.5%	298	71.3%	257	50.0%	38	56.7%
TOTAL	**396**		**418**		**514**		**67**	
Punishment	**Fraud**		**Ins Fraud**		**Other**		**Total**	
No Loss	15	7.1%	21	6.1%	48	22.3%	196	9.1%
Monitoring	58	27.6%	115	33.5%	63	29.3%	568	26.3%
Temp Loss	12	5.7%	11	3.2%	8	3.7%	97	4.5%
Indef Susp	4	1.9%	1	0.3%	9	4.2%	90	4.2%
Perm Loss	121	57.6%	195	56.9%	87	40.5%	1212	56.0%
TOTAL	**210**		**343**		**215**		**2163**	

mitted in-state, the number drops to 17.7% for cases involving felonies committed out-of-state. This is understandable, of course, in the sense that the state has the above described interest in pre-

TABLE 5: PUNISHMENTS & LOSS OF LICENSE, 1990-2007 (NEW YORK + SISTER-STATES)

Punishment	**NY**		**Sister-States**		**Total**	
No Loss	132	10.7%	64	6.9%	196	9.1%
Monitoring	403	32.8%	165	17.7%	568	26.3%
Temp Loss	74	6.0%	23	2.5%	97	4.5%
Indef Susp	42	3.4%	48	5.1%	90	4.2%
Perm Loss	578	47.0%	634	67.9%	1212	56.0%
TOTAL	**1229**	**56.80%**	**934**	**43.20%**	**2163**	

serving its own "public health"—and thus it makes sense to assign resources to police physicians in New York and hopefully rehabilitate or otherwise prepare them for their return to good graces within the community. Conversely then, one would expect the state to have less of an evident interest in investing public or peer resources in supervising those whose offenses were committed *out-of-state*, even if they maintain licenses to practice within New York. Consistent with this generally parochial attention, these data sug-

gest that New York State is harsher on offenses committed out of state than it is on offenses committed within its own borders. As once again shown in Table 5 (we first saw this in Table 3), 47% of cases involving New York felonies led to a permanent loss of one's license, compared to the permanent loss of one's license in 67.9% of cases involving felonies committed out of state.

Table 6 continues these comparisons, focusing on the punishments meted out by New York State to those issued by sister-states (for physicians holding licenses in both jurisdictions), and demonstrates almost without exception, that the severity of the punishment is *greater* in New York for these out of state offenses than is the punishment handed down in the original state.[104] There are a few possible explanations for the higher rate of permanent license loss for this increased severity. The first is that other states may be more consistently reporting their felony offenses than non-felony offenses to New York. This biases the sample New York receives in favor of the harshest punishment. Another possible explanation is that physicians are less likely to attempt to fight to keep their license in New York if they have committed a felony offense in another state but have not lost their license; or, if they have had their license restored and, as a consequence, their New York license is less important to them. A related explanation is that it is difficult for physicians to fight a case remotely, without an attorney familiar with the New York system. Another possible explanation is that New York is more severe with its punishment than other states and perhaps attorneys in other states are less careful in trying to structure the language in the disposition of the criminal case. Below we will see that particular language at the plea stage can be very harmful in the subsequent New York licensing proceeding.

We turn now to the post-discipline situation of affected physicians and begin with indefinite suspensions. To determine whether a physician was suspended for the actual time they had been sentenced, all suspended physicians were checked against DOE's Office of the Professions professional search tool. These records report the license status of physicians, so that if they had their license reinstated before the end of their sentence, the data would reflect it. We cross-referenced this with our records of recidivists to create a full record of what happened to each physician who had his or her license suspended. We see in Table 7 that 13.6% of physicians who were given indefinite suspensions received their licenses back, and six or 3.7% (not shown) recidivated after

[104] Importantly, the out-of-state offense must be one that is similarly an offense in New York.

TABLE 6: SEVERITY OF PUNISHMENTS FOR FELONY OFFENSES, (NEW YORK VS. SISTER-STATES)

			Sister-State Punishments											
NY Punishment														
	None		**Unknown***		**Cens/rep**		**Fine**		**Conditions**		**Probation <3**		**Probation >3**	
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lesser	0	0.0%	0	0.0%	1	1.8%	8	22.9%	12	9.8%	10	15.2%	13	7.6%
Equal	2	33.3%	1	11.1%	20	35.7%	7	20.0%	3	2.5%	17	25.8%	43	25.3%
Greater	4	66.7%	8	88.9%	35	62.5%	20	57.1%	107	87.7%	39	59.1%	114	67.1%
TOTAL	**6**	**0.6%**	**9**	**1.0%**	**56**	**6.0%**	**35**	**3.8%**	**122**	**13.1%**	**66**	**7.1%**	**170**	**18.3%**
NY Punishment														
	Suspension <1		**Suspension >1**		**Indef**		**Clinical Lim**		**Surrender**		**Revocation**		**Total**	
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lesser	2	11.8%	14	21.2%	11	18.6%	1	50.0%	18	10.3%	15	10.1%	105	11.3%
Equal	1	5.9%	4	6.1%	16	27.1%	0	0.0%	157	89.7%	133	89.9%	404	43.4%
Greater	14	82.4%	48	72.7%	32	54.2%	1	50.0%	0	0.0%	0	0.0%	422	45.3%
TOTAL	**17**	**1.8%**	**66**	**7.1%**	**59**	**6.3%**	**2**	**0.2%**	**175**	**18.8%**	**148**	**15.9%**	**931**	

*** Judged to be equal to censure; anything greater than this was coded accordingly**

TABLE 7: PHYSICIAN POST-DISCIPLINE STATUS (SUSPENSIONS)

					Length of Suspension					
	<1 yr		**1-2 yr***		**2-3 yr***		**3 yr**		**4 yr**	
Reinstated	53	100.0%	20	60.6%	7	43.8%	3	33.3%	0	0.0%
Later Infraction	0	0.0%	4	12.1%	1	6.3%	0	0.0%	0	0.0%
Susp (w/in actual)	0	0.0%	1	3.0%	1	6.3%	0	0.0%	1	50.0%
Susp (>original)	0	0.0%	1	3.0%	2	12.5%	1	11.1%	0	0.0%
Inactive	0	0.0%	7	21.2%	5	31.3%	5	55.6%	1	50.0%
TOTAL	**53**		**33**		**16**		**9**		**2**	
	5yr		**>5yr**		**Indef**		**Total**			
	1	16.7%	0	0.0%	22	13.6%	106	37.7%		
	0	0.0%	0	0.0%	16	9.9%	21	7.5%		
	0	0.0%	0	0.0%	99	61.1%	102	36.3%		
	1	16.7%	0	0.0%	4	2.5%	9	3.2%		
	4	66.7%	0	0.0%	21	13.0%	43	15.3%		
	6		**0**		**162**		**281**			

regaining their licenses. This means that 86.4% of all physicians given indefinite suspensions did not receive their license back, which constitutes a *de facto* permanent punishment.[105] One important explanation for why a physician does not attempt to regain a license after an indefinite suspension is that indefinite suspension was frequently used for chronic problems, such as drug infractions. One respondent indicated that this kind of chronic problem was associated with a high recidivism rate, and, therefore, indefinite suspensions coupled with other requirements were frequently utilized.[106]

In the same vein, Table 8 looks at post-discipline situations for those whose licenses were either revoked or surrendered. Surrenders and revocations were statutorily permanent, and, officially, no physician could reapply for three years after having surrendered a license or having had it revoked. Respondents also indicated that it took another year to process reapplications, so the punishment became a minimum of four years. Data on restorations appear in physician disciplinary records, the same records used to obtain our larger data set. We noted above, however, that hearings for restorations are held by the New York DOE, and although there is no

[105] As one respondent explained to us, "Their [those giving indefinite suspension] intention is to be a permanent revocation." Interview #5, *supra* note 68.

[106] Interview with New York state official in New York, N.Y. (Sept. 17, 2007) [hereinafter Interview #3].

TABLE 8: PHYSICIAN POST-DISCIPLINE STATUS (REVOCATIONS AND SURRENDERS)

Year	Revocation	Surrender	Restor Denied	Restor Granted	Restor Requests	% Restored	Later Infraction	% Recidivist
1989			2	0	2	0.0%	2	0.0%
1990	24	6	0	0	0	0.0%	0	0.0%
1991	18	13	1	5	6	83.3%	1	20.0%
1992	24	29	1	1	2	50.0%	1	100.0%
1993	55	38	0	2	2	100.0%	1	50.0%
1994	57	65	2	1	3	33.3%	1	100.0%
1995	84	79	3	3	6	50.0%	0	0.0%
1996	74	95	6	2	8	25.0%	0	0.0%
1997	70	85	5	8	13	61.5%	0	0.0%
1998	45	102	3	4	7	57.1%	1	25.0%
1999	53	94	14	2	16	12.5%	1	50.0%
2000	49	99	8	3	11	27.3%	0	0.0%
2001	37	96	9	1	10	10.0%	0	0.0%
2002	54	82	4	1	5	20.0%	0	0.0%
2003	40	57	2	0	2	0.0%	0	0.0%
2004	50	87	7	1	8	12.5%	0	0.0%
2005	49	66	4	0	4	0.0%	0	0.0%
2006	62	69	2	0	2	0.0%	0	0.0%
2007	86	57	0	0	0	0.0%	0	0.0%
Sub-total	**931**	**1219**	**73**	**34**	**107**	**31.8%**	**6**	**17.6%**
TOTAL		**2150**						

record of restoration attempts in the Department's data sets, we proceed on the assumption that OPMC data set contains a complete set of all restoration data.

We should stress three items of interest in this table. First, of late, and for a considerable stretch of time (1996-2006), "Surrender" was a more popular option than "Revocation," besting the latter by more than double in some years (e.g. 1998). Second, we can see from the Table 8 data that only 1.6% of those who surrendered or had their licenses revoked eventually received their license back, meaning of course that 98.4% of affected individuals did *not* have their licenses restored. However, note too that only 107 of the relevant population of 2,150 even *attempted* to have their license restored (5.0%). Third, note that only 31.8% of restoration efforts were successful. This suggests very serious consequences indeed for the physicians; however, it is also important to surface many of the explanations from our interviews which suggest that the reality may not be quite as bleak as it appears.

First, some physicians simply may not try to get their licenses back because they have licenses in other states, and a New York license is unnecessary for them to practice in that state. Second, physicians, even in New York, may be able to obtain jobs without a license on the basis of their medical degrees (i.e. for pharmaceutical companies, biotechnology, or even reviewing medical records). On the other hand, some physicians may contemplate trying to regain their license, but may conclude for one or more reasons that it is simply not worth it. For instance, the earlier conviction may make it difficult for them to get malpractice insurance. They might also perceive the system as too harsh and doubt their chances of restoration success. Finally, there is the simple fact that—in light of our data—those physicians who lose their licenses are the worst half of the worst offenders, worse than those who were similarly charged but did not lose their licenses.

Our final set of findings pertains to rates of recidivism for these offenders. Table 9 compares the first and second punishments that physicians received, including data for both New York and sister-states and including both felony and non-felony offenses. As we can see, there were 379 recidivists in our set of 4,739 infractions, making for a rate of 8.0%. Considering only felonies, there were 148 recidivists, for a rate of 6.8%. Of those physicians who surrendered or had their licenses revoked—but who did receive their licenses back—17.6% committed another infraction. For physicians who were suspended indefinitely, but who had their licenses restored, the recidivism rate was 27.3%. We would be less than frank if we did not admit that these high rates of re-offending genuinely surprised us, giving us pause to consider the degree to which our own middle-class values led us to expect that more offenders would "learn their lesson" the first time.

V. Discussion

This study has been a first attempt to understand the rich and complicated process of punishing physicians in the state of New York. While one would expect that felony offenses invariably lead to the most serious penalty—the revocation of one's license—we have demonstrated that this is not the case. We turn now to several themes for discussion of these data, drawing out the implications of our work for the study of the law and politics of the licensing pro-

TABLE 9: SEVERITY OF PUNISHMENTS FOR FELONY & NON-FELONY RECIDIVISTS (NEW YORK + SISTER-STATES

				***Original* Sanction**										
***Subsequent* Sanction**														
	None		**Unknown***		**Cens/rep**		**Fine**		**Conditions**		**Probation <3**		**Probation >3**	
Unknown	0	0.0%	0	0.0%	1	1.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lesser	0	0.0%	0	0.0%	2	3.4%	1	20.0%	4	17.4%	13	15.1%	28	19.9%
Equal	0	0.0%	0	0.0%	5	8.5%	1	20.0%	1	4.3%	6	7.0%	26	18.4%
Greater	7	100.0%	1	100.0%	51	86.4%	3	60.0%	18	78.3%	67	77.9%	87	61.7%
TOTAL	**7**		**1**		**59**		**5**		**23**		**86**		**141**	
	Suspension <1		**Suspension >1**		**Indef Susp**		**Clin Lim**		**Surrender**		**Rev**		**Total**	
Unknown	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	0.3%
Lesser	3	27.3%	6	54.5%	6	21.4%	0	0.0%	0	0.0%	2	100.0%	65	17.2%
Equal	0	0.0%	0	0.0%	2	7.1%	0	0.0%	1	100.0%	0	0.0%	42	11.1%
Greater	8	72.7%	5	45.5%	20	71.4%	4	100.0%	0	0.0%	0	0.0%	271	71.5%
TOTAL	**11**		**11**		**28**		**4**		**1**		**2**		**379**	

* Judged to be equal to censure; anything greater than this was coded accordingly

cess, the nature of "professional" punishment, if you will, and the administration of disciplinary proceedings in general.

A. Reporting

One of the most striking and surprising findings of our interviews was learning that there is no automatic nor necessarily reliable and consistent information flow between the courts of other states and the New York disciplinary board nor even between New York courts and the New York disciplinary board in reporting case dispositions. Apparently some courts automatically report all convictions of physicians. Others, however, simply do not. Thus we learned that it is not uncommon for OPMC to learn about convictions from other sources such as newspapers. One respondent asked, "How many cases are [OPMC] not hearing about? Who knows?"[107] Other respondents reiterated that there was no automatic mechanism through which New York found out about cases, though the Federation of State Medical Boards maintains that there is in fact perfect reporting between states that utilize their pay service. Finally, we simply do not know the extent, if any, to which negotiations include acquiescence by attorneys in criminal matters and insurance companies in other matters to accept restitution in return for not reporting the matter to OPMC, although we found suggestive evidence from our interviews that issues like this do frequently arise. These may be reasons for the disparity between cases originating in New York and elsewhere. As we will note later, this is an avenue for further research.

B. Negotiations

We anticipated that there would be substantial coordination of responsibilities (between attorneys regarding the distinct criminal and licensing matters) and plea bargaining at the criminal conviction stage with respect to pleas and subsequent license revocation, but with a few exceptions, our research did not reveal such practices in general. We did find, however, that attorneys at the licensing stage, without exception, bemoaned the fact that they were not involved at the plea stage and felt that their input could be signifi-

[107] Interview #6, *supra* note 71.

cant. Surprising was the fact that criminal attorneys regularly handled the criminal case, and then licensing attorneys handled the licensing case—with only occasional instances of collaboration.[108] Respondents reported that attorneys who were most responsible for subsequent licensing hearings at OPMC and DOE were not at all involved in the criminal court disposition. In the rare instances where these attorneys were consulted by the criminal defense attorney and/or in which they had a more direct role in the criminal disposition, it was felt that even if the bargaining could not directly involve licensing, a final criminal court package could be structured in a way more or less favorable to the physician.

The most vivid illustration of this point was given by an attorney lamenting his lack of participation at the trial stage. He noted that all too often the defense attorney at this stage pleads for leniency before the judge in the criminal court disposition, arguing that his client will be losing his license and thus already will be paying a big price. Licensing attorney respondents simply hated when criminal defense attorneys said this because statements from the criminal trial enter BPMC hearings as fact; respondents felt it almost precluded BPMC from making a more lenient decision (for example, licensing suspension and not revocation). If an attorney says, "My client will lose his license," as an argument for leniency, it is an invitation for BPMC to do just that. In borderline cases, it can tip the hearing boards, and licensing attorneys argue that the criminal trial attorneys ought to "resist the temptation" [109] to proffer predictions about BPMC actions. When judges made comments like, "I'm giving him a light penalty because I expect him to lose his license,"[110] licensing attorneys knew that their clients had very little chance of a good disposition. Had they been involved in the plea before the judge, the licensing attorneys maintained that they would never have predicted loss of their client's license before the judge. Instead, respondents advised that defense attorneys should argue along the lines of: "my client has suffered enough."

Interestingly, we also learned that "mutual gains," or "value-creating," or "problem solving" bargaining does occasionally take place with those responsible for licensing.[111] The best example

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108 In our earlier study, in N.J., we found that these were called the "global resolutions" of the dispute. *See* Heumann et al., *supra* note 17.

109 Interview #5, *supra* note 68.

110 Interview #2, *supra* note 69.

111 For a more extensive discussion of this kind of bargaining, see D. LAX & J. SEBENIUS, THE MANAGER AS NEGOTIATOR: BARGAINING FOR COOPERATION AND COMPETITIVE GAIN (1987). For specific examples of negotiations, which can productively introduce "problem solving" op-

arose in a case where a physician was accused of poor and sloppy record keeping. Rather than suspend the physician, the attorney successfully argued for allowing the doctor to continue to practice, but with strict supervision of his office. Thus, by "enlarging the pie," the respondent argued, both the physician and the public's interests could be served. More generally, and not surprisingly, respondents reported active negotiations on all aspects of the licensing decision, but note again that these were undertaken *after* the criminal conviction was already handed down. Although we have no data to corroborate the estimation, multiple respondents with an intimate knowledge of the process indicated that about half of cases were by consent.[112] As one respondent said, "We look at the cases and we all know what they're worth."[113] Another respondent agreed, saying, "I have a very good sense. It's almost self evident."[114] What's more, respondents weren't cynical about this plea bargaining, and indicated that case pressure was probably not the reason they negotiated because, as they perceived it, "[OPMC] is not drowning in cases."[115]

C. Prescriptions

In the course of our interviews, we were intrigued by the advice attorneys frequently gave as their physician-clients attempted to retain their licenses or sought to have them restored after suspension or revocation. Such instructions—which we will refer to as the physician's (and counsel's) *prescription*—comprise three critical, distinct, and yet still inter-related "R's:" (i) Remorse; (ii) Rehabilitation; and (iii) Reeducation.

1. Remorse

The first "R" calls for the physician to admit his culpability and exhibit genuine contrition in conceding the error of his ways. As one attorney put it, "You wanna [sic] knock their socks off to be a doctor again. They want you to crawl."[116] Another agreed, telling-

tions, see M. Heumann & J. Hyman, *Negotiation Methods and Litigation Settlement Methods in New Jersey: 'You Can't Always Get What You Want,'* 12 OHIO ST. J. ON DISP. RESOL. 200 (1997).

[112] Interview #1, *supra* note 71; Interview #6, *supra* note 71.

[113] Interview #6, *supra* note 71.

[114] Interview #5, *supra* note 68.

[115] Interview #6, *supra* note 71.

[116] Interview #2, *supra* note 69.

ing physicians, "It must be the biggest *mea culpa* of your life."[117] Time and again, though, we were told by their attorneys that in this area, physicians were simply terrible clients. First, despite pleading guilty to a criminal charge, the physicians often tried to continue to argue their innocence. They frequently disobeyed attorneys who told them that "if there is 10% backsliding in [a physician's] testimony that is what will be focused on."[118] They elaborated upon what they saw as exculpatory considerations which removed their responsibility for the action or suggested that it was really another person's fault. Sex offenders often offered an excuse ("She was asking for it"), coupled with graphic discussions of how the victim would physically come closer than necessary to the physician (e.g., "She wiggled her hips and pushed her pelvis up slightly, and I took it to mean that she wanted it").[119]

In a related sense, our interviewees disclosed that physicians were frequently unable show sincerity in admitting contriteness for their actions; the egos of many physicians interfered with their acceptance of responsibility and expressions to the court. For example, a defense attorney reported that his client said to the board, "I don't think I did anything so bad." At this point, the defense attorney told us, "I thought to myself, 'There goes another three years!' "[120] But in a more general way, respondents reported that physicians made difficult clients since they were accustomed to leadership positions and a particularly high status. "Doctors think they have earned their right to practice, whereas the state regards it as a privilege."[121] We were bombarded with supporting anecdotes in this regard. Physicians, we were told, introduced themselves to acquaintances, as "*Dr.* So and So," with titles substituting for first names: in other words, "It is not just their job, it's who they are."[122] We were even told, perhaps apocryphally, that M.D. appellation is not uncommonly included on tombstones.[123] This further contributed to the difficulty physicians had regaining their licenses. One respondent painted a particularly bleak picture. As they lost their licenses, their lives "fell apart." That is, they "have to deal with an angry wife no longer married to a doctor, usually get divorced, have child support, fall out with their friends, and

117 Interview #5, *supra* note 68.
118 Interview #2, *supra* note 69.
119 Interview #2, *supra* note 69.
120 *Id.*
121 Interview #3, *supra* note 106.
122 Interview #2, *supra* note 69.
123 *Id.*

have no money left and no will to fight."[124] This was suggested as one reason some physicians did not eventually reapply for their licenses.

2. Rehabilitation

The second ingredient of the physician's prescription, *Rehabilitation*, maintains that the client should seek psychological counseling or other treatment for a problem—and an even more specific avenue is for a physician to enroll with the Committee on Physician Health ("CPH"). This private agency is linked to the New York Medical Association and is the most visible of the private organizations which afford physicians an opportunity to address underlying alcohol and drug problems. CPH provides diagnostic and advisory provisions and oversees the rehabilitation process, but actually does not provide rehabilitation services directly. Rather, CPH refers physicians to approved in-patient and out-patient drug treatment centers, drug testing services, psychiatrists, and other appropriate health professionals. CPH is an important vehicle for physician reentry in the profession. Though it is not required by license reapplication committees, many respondents indicated that CPH had much credibility with BPMC. Some attorneys, though, were reluctant to use CPH because of its onerous requirements, believing that they could fare as well or better with their clients without exposing them to the cost of CPH, as well as the arduous formal monitoring CPH requires. As one attorney said, "I have butted heads with CPH a lot. They are good advocates at OPMC, but the cure is often worse than the disease."[125] Respondents also indicated that the services CPH referred to were very expensive.[126] "[It is] inconvenient, expensive, and terrifying. Doctors enter the program kicking and screaming."[127]

3. Reeducation

Finally, in seeking penance and a "second chance," an offending physician should be prepared to document his/her *Reeducation*. This could come in the form of course work, ethics classes, or other forms of training. In a practical sense, reeducation sometimes allows physicians convicted of both professional offenses and criminal offenses to continue to practice under a probationary

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[124] *Id.*

[125] Interview #5, *supra* note 68.

[126] *Id.*

[127] Interview #3, *supra* note 106.

punishment as long as they meet reeducation conditions;[128] but in a more symbolic sense, it works in-step with the first two elements (remorse and rehabilitation) to indicate that the individual has taken responsibility for his actions, has attempted to make amends, and is serious about not reoffending in the future. These three "Rs" do not, of course, constitute the universe of sentiments and sensibilities that client and counsel should convey, but our research indicates that this "prescription" captures the basic components of a successful endeavor within such proceedings.

VI. Conclusion

As we have suggested throughout this Article, thinking of discipline in black-and-white, all-or-nothing, terms misses much of the significance of the politics of the professional discipline process. What is critical is that there are a range of penalties for felony offenses short of revocation just as there are a range of penalties employed for various professional infractions. In this study, we have tried to understand the processing of these felony offenses by the various state boards. Still, to fully appreciate the intricacies and implications of these matters, more research is needed. And, thus we conclude with some general thoughts regarding the direction such studies should take.

First, and perhaps foremost, a series of interviews with physician offenders would add an important dimension to our analysis. We think it crucial to understand the way offenders perceive the sanctioning process and the process that confronts them in keeping or having a license restored. The issue of how much an attorney and a judge should advise a client about collateral penalties is something that is not well enough explored in the literature.[129] Indeed, an intriguing contention that emerged from our interviews involved attorney responsibilities in advising clients about the col-

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[128] For professional offenses, it was common for reeducation courses to emphasize such matters as better medical record keeping. In criminal matters, ethics courses were more common. For 37.5% of non-felony offenses, some form of probation was given, and in 25% of the felony offenses, probation was meted out. For most of these cases, reeducation was a condition of probation.

[129] *See, e.g.,* Gabriel Chin & Richard Holmes, Jr., *Effective Assistance of Counsel and the Consequences of Guilty Pleas,* 87 Cornell L. Rev. 692 (2002) (discussing an attorney's obligations to advise her client of various collateral consequences attaching to a guilty plea); *see also* Ewald & Smith, *supra* note 19 (providing empirical evidence of the relative degree to which a sample population of attorneys is aware of such consequences).

lateral consequences of criminal pleas and of the collateral consequences even when a license is restored. For one thing, we learned that, at the criminal court level, many attorneys failed to advise their clients about licensing consequences, often because they simply were not well versed in the extent—or even existence—of such consequences. At a later stage, when clients were in the process of hiring attorneys for license proceedings, we also discovered a similar range of attorneys' cautions about collateral punishments. Some took the case simply with the goal of minimizing OPMC punishment and/or getting a physician reinstated to practice. Others, who invariably felt proudly ethical about their "truth in representing" policy, went out of their way to specifically tell physicians about a range of collateral punishments, e.g. failure to be eligible for third party, Medicare, or Medicaid payments for a number of years even if licenses were restored. And, as one respondent noted, "Judges feel that it's not their job to discuss the collateral penalties that one can incur, it is their lawyer's job."[130]

Second, a more detailed look at the recidivists in our data set could be quite instructive. What variables are associated with physicians who, after having been sanctioned, commit yet another offense? Third, it would be interesting to assess whether there is a relationship between the severity of sanctions of physicians and the need for physicians in a state. In a gross way, one could compare penalties with physicians per capita and hypothesize that as demand for physicians increases, permanent sanctions decrease.

Finally, there is an important normative question suggested by these data. About half the physicians who commit felony offenses are able one way or another to continue in their profession. It would be worth exploring if the same can be said for offenders in other fields. To what extent does a felony offense preclude someone—for example, a teacher—from continuing his or her job? This is not an argument about not giving doctors a second chance; as a policy matter, we think that there ought to be greater use of alternative sentences for physicians. What we are reflecting on is whether the potential for a second chance given to physician felony offenders in New York is something equally available to other offenders in other fields and, as our earlier work indicates, in other states.[131]

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[130] Interview #2, *supra* note 69.

[131] *See* Pinaire et al., *supra* note 12; *see also* Heumann et al., *supra* note 10 (both involving studies of disciplinary law and politics in New Jersey).

Appendix: Coding Explanations for Quantitative Data (1990-2007)

The following punishments are listed in their order of harshness. Admittedly, there is some imprecision in our ordinal use of "harshness" as standard. Consider, for example, that fines can reach as high as $100,000, which may appear more "harsh" than probation, and probation may actually last only as long as the period of the investigation. That said, the coding we present here embodies the harshness of the overall set of cases. As with much of our data, there was individual variation within these categories.

1. "None:" No penalty was imposed on the physician. Also included in this category is the lifting of restrictions, conditions, or suspensions.
2. "Unknown:" The punishment given to the physician was not listed within OPMC's records or did not otherwise fit within the other categories. The sample size on this category was very small.
3. "Fine:" The physician was ordered to pay a monetary fine.
4. "Censure/Reprimand:" The physician was issued a formal letter of reprimand or censure.
5. "Conditions:" The physician was required to perform some activity or to undergo some training. These include any and all conditions that do not fall within the bounds of the other categories, including performing a certain number of hours of community service, completing a Continuing Medical Education course, having one's license limited, being unable to perform certain procedures, etc.
6. "Probation <3:" The physician was placed on probation for less than three years. Physicians were frequently put on probation during the time of their investigation and then taken off immediately when they were absolved. Interviewees indicated that terms of probation often included "boiler plate conditions" that involved monitoring of physician practices, checking in with probation officers, drug testing, or other conditions. The difference between "conditions" and "probation" for our purposes is the time-bound nature of the latter, although we concede the thin line between the two in some respects. Note, as well, that stayed suspensions were coded as "probation" because in effect the two were the same and differed only in name.

7. "Probation >3:" The physician was placed on probation for greater than three years. This also includes indefinite probations.
8. "Suspension <1:" The physician was suspended from practicing medicine for some period less than a year. Included within this category are physicians suspended for the length of investigation and later absolved. At the end of a suspension period physicians need not reapply before practicing medicine again.
9. "Suspension >1:" The physician was suspended from practicing medicine for some period more than a year, but with some end point. Note that physicians suspended for *exactly* one year were included in this category. Frequently this was followed by a probationary period.
10. "Indefinite Suspension:" The physician was suspended from practicing medicine for an indefinite period. Temporary suspensions were included in this category, as were "Section 13" Surrenders, a temporary surrender that often resulted in a physician having their license restored after drug or psychiatric treatment.
11. "Clinical Limitation:" The language for this infraction read, "physician may not have contact with patients, clinical or otherwise." Respondents indicated that physicians who received this punishment were essentially barred from practice but were allowed to keep their licenses. Interestingly, they were not able to perform duties such as checking the medical records of other physicians for insurance companies, so it is not clear what benefit the physicians gained from this as opposed to a surrender or revocation. This punishment was also de facto permanent and very few cases were found in which physicians later practiced after this punishment. We assume that physicians were able to engage in scientific or pharmaceutical research in a capacity without patient contact and retaining one's license granted some additional prestige with employers.
12. "Surrender:" The physician voluntarily agreed to surrender his or her license to the state medical board and discontinue the practice of medicine. We will explore the different reasons that one might voluntarily surrender one's license instead of going to a hearing and receiving a revocation within the body of the paper. Here we will

note that within the disposition of punishment, there was frequently no restriction on how soon a physician could reapply for licensure in New York. Some dispositions, however, did include caveats that a physician must wait one or two years to reapply, meaning that they would be able to reapply sooner than with a revocation.

13. "Revocation:" The New York Medical Board revoked the physician's license. Most of these physicians took their cases to the hearing stage but lost their ability to practice medicine. Physicians were not able to reapply for licensure for three years after losing their license.
14. "Permanent Revocation:" The language for this punishment reads: "The physician agrees to never reactivate his registration or reapply for a license to practice medicine in New York State." These punishments began appearing within our records predominantly in 2003, although some did occur as early as 2000. Respondents indicated that no one had yet tried to reapply after receiving this punishment but might be able to successfully argue that OPMC was beyond its authority to issue such punishments. They indicated, however, that the Board liked using this punishment because "[i]t certainly looks permanent."
15. "No License:" Medical students were found practicing medicine and their punishments were included within OPMC's data set. These were coded like other physician infractions, especially because these students had frequently finished medical school but had not passed the required exams to receive their license. Medical students were also precluded from ever receiving a New York State medical license.