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

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

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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

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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]

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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

[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

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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**		