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-

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-

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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-

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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.