ARTICLES

PRESCRIBING JUSTICE: THE LAW AND POLITICS OF DISCIPLINE FOR PHYSICIAN FELONY OFFENDERS

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ABSTRACT

This paper explores the collateral consequences of felony convictions for physicians' licenses in New Jersey. The research relies primarily on an analysis of a data set we compiled by reviewing disciplinary actions taken by the New Jersey Board of Medical Examiners (BME) as well as data we collected through interviews with deputy attorneys general and defense attorneys. We begin by first attempting to piece together the puzzle of quantitative data which suggest harsh sanctions on physicians' licenses on the one hand, and interview data indicating BME leniency on the other (particularly as compared with other professions—e.g. attorneys in New Jersey). Second, we find evidence of a "second-chance tradition" for errant physicians. Specifically, we find that license revocation is not permanent, although it is also the case that most doctors do not attempt to have their licenses reinstated. We also explore the various alternative forms of discipline imposed upon doctors, including private sanctions, chaperones, and various rehabilitation programs. Finally, we offer preliminary thoughts about physician discipline as compared to the discipline of attorneys and "regular offenders," and conclude with a call for future research to be systematic and comparative, extending across professions and jurisdictions.

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I. INTRODUCTION

Anyone can make mistakes, exercise poor judgment, or commit criminal offenses or various other indiscretions. Physicians, by virtue of the responsibility assigned to the medical profession, are held to a higher standard than the average person. When a doctor causes harm, either inadvertently or intentionally, criminal charges may apply for violations of the law and civil suits are options for individuals who allege malpractice, but how are physicians held accountable for their breach of the public's trust? In other words, how are physicians who have committed acts of malfeasance against the polity scrutinized and adjudged?

The present study, while admittedly exploratory, is nevertheless one of the first attempts at a comprehensive study of the law and politics of discipline for physician felony offenders. Our examination draws upon the recent scholarly attention directed toward punishments "beyond the sentence" for felons *as a class* of offenders in the American criminal justice system.[1] Such consequences, referred to by Lewis Lawes, the renowned warden of Sing Sing Correctional Facility, as "invisible stripes,"[2] are "worn" by the offender as an indicator—a label of sorts—long after the convicted individual has served his or her time for the crime.[3] Indeed, in an exhaustive study of the problematic "invisibility" of such punishments, John Jay College President Jeremy Travis has stressed that while such criminal sanctions "are not as obvious as some others, they may in fact be more pernicious because they make it more difficult for ex-felons to gain a foothold in free society."[4] Along the same lines, the criminologist Joan Petersilia reminds us that "[c]onvicted felons may lose many essential rights of citizenship"—including the right to vote in nearly every state (for some duration), as well as the rights to serve on a jury and run for office in almost all states.[5] Moreover, ex-offenders are "often restricted in their ability to obtain occupational and professional licenses," a collateral sanction which obviously inhibits employment options and which may ironically "create formidable obstacles to law-abidingness."[6]

Previous studies of the nature and effects of such punishments beyond the

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[1] 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).

[2] See LEWIS E. LAWES, INVISIBLE STRIPES (1938).

[3] *See, e.g.*, Harold Garfinkel, *Conditions of Successful Degradation Ceremonies*, 61 AM. J. SOC. 420-24 (1956) (arguing that that the stigma attached to former prisoners is successful at effecting degradation which lasts far beyond a prisoner's release).

[4] JEREMY TRAVIS, BUT THEY ALL COME BACK: FACING THE CHALLENGES OF PRISONER REENTRY 63 (2005).

[5] JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 105 (2003).

[6] *Id.*

sentence—referred to generally as "collateral consequences"[7]—have focused on public attitudes towards the disenfranchisement of individuals with felony convictions,[8] including the first-ever public opinion data.[9] This research has in turn inspired considerable political mobilization and activity in multiple states.[10] Previous research has also delved into the form and degree of public support for a broader range of collateral punishments, including restrictions on employment, the deprivation of various state benefits and opportunities for rehabilitation or restitution,[11] and the process and politics of discipline for members of the legal profession who have been convicted of, or who are facing, felony charges.[12] However, as the more global dilemmas of reentry become known, the more particular issue of professional licensing restrictions has not been sufficiently addressed. Thus, this article seeks to fill this gap in the literature, paying attention to the political salience of restrictions on occupational licensing. Sanctions of this sort typically fly under the proverbial radar, at least in part because they flow from complicated intersections of state, quasi-state, and private associations.

To facilitate this understanding we rely on the case study method, looking at one profession in depth in one state, to accomplish three principal objectives. Our first goal is to systematically document the collateral punishments for phy-

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[7] *See generally* INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT 15 (Marc Mauer & Meda Chesney-Lind eds. 2002); JUSTICE KENNEDY COMM'N, AM. BAR ASS'N, REPORTS WITH RECOMMENDATIONS TO THE ABA HOUSE OF DELEGATES (2004); TRAVIS, *supra* note 4.

[8] *See* ELIZABETH HULL, THE DISENFRANCHISEMENT OF EX-FELONS (2006); JEFF MANZA & CHRISTOPHER UGGEN, LOCKED OUT: FELON DISENFRANCHISEMENT AND AMERICAN DEMOCRACY (2006); Brian Pinaire, Milton Heumann & Laura Bilotta, *Barred from the Vote: Public Attitudes Toward the Disenfranchisement of Felons*, 30 FORDHAM URB. L.J. 1519 (2003); ALEC EWALD, A 'CRAZY QUILT' OF TINY PIECES: STATE AND LOCAL ADMINISTRATION OF AMERICAN CRIMINAL DISENFRANCHISEMENT LAW (2005), *available at* http://www.sentencingproject.org/Admin/Documents/publications/fd_crazyquilt.pdf.

[9] *See* Pinaire et al., *supra* note 8. For public opinion research conducted subsequent to this study but which affirms its central conclusions, see Jeff Manza, Clem Brooks & Christopher Uggen, *Public Attitudes Toward Felon Disenfranchisement in the United States*, 68 PUB. OP. QUART. 275 (2004) (finding that in most cases, the public views the voting restrictions on ex-felons as a violation of the ex-felons' civil liberties).

[10] *See, e.g.*, MARC MAUER & TUSHAR KANSAL, BARRED FOR LIFE (2005), *available at* http://www.sentencingproject.org/Admin/Documents/publications/fd_barredforlife.pdf (finding that it remains difficult for convicted felons to register to vote despite recent legislative action).

[11] *See* Milton Heumann, Brian Pinaire & Thomas Clark, *Beyond the Sentence: Public Perceptions of Collateral Consequences for Felony Offenders*, 41 CRIM. L. BULL. 24, 30-38 (2005).

[12] *See* Brian Pinaire, Milton Heumann & Jennifer Lerman, *Barred from the Bar: The Process, Politics, and Policy Implications of Discipline for Attorney Felony Offenders*, 13 VA. J. SOC. POL'Y & L. 290, 300-303, 312-318 (2006).

sicians who have committed felony offenses. In doing so, we have gathered, systematized, and analyzed original data that has previously been unavailable to researchers, and thus our findings illuminate the heretofore murky domains of discipline of doctors *by* doctors. Second, building on our previous study of the disciplinary process for New Jersey attorneys,[13] we will propose the first of its kind comparative assessment of the legal and political implications of licensing restrictions for offenders drawn from two different occupations: both occupations are professions and require licensure for practice, but they differ significantly with respect to sanctioning practices. Finally, taking advantage of the freedom afforded by an exploratory study of this sort, we will harness these data and conclusions to reflect in a general way on the broader implications of punishment for professionals who are in some sense custodians of public health.

In Section II below we begin with an overview of general occupational licensure and the history of medical licensing. We also discuss the role played by state medical boards across the nation, with attention to their purpose and process. Section III attends to the disciplinary process in New Jersey, a state with approximately 32,500 licensed physicians.[14]

In Section IV we discuss our collection and research methods for attaining these data, which include extensive interviewing of elites involved in the regulatory process, information analyzed from our quantitative data set of sanctions, and observations derived from attendance at disciplinary proceedings. We conducted a total of eleven interviews, generally in teams of two authors, with New Jersey state officials in the Office of the Attorney General and with defense attorneys practicing in the state. To preserve the anonymity of our respondents, we have assigned numbers to the interviews conducted, we will refer to all respondents as males, and we will not include any identifying background matter. Each of the interviewees has experience on one or both sides of the disciplinary process and each afforded us unlimited time, both in person and during follow-up phone calls for clarification purposes. Our questions explored the respondents' roles in the system and their perceptions of the disciplinary process.

Section V will present our basic conclusions, classifying both the primary offenses committed by New Jersey physicians and the sanctions imposed against them. We proceed to discuss our findings in Section VI and conclude in Section VII with some suggestions for further study.

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[13] Id.

[14] FEDERATION OF STATE MEDICAL BOARDS, TRENDS IN PHYSICIAN REGULATION 35 (April 2006), http://www.fsmb.org/pdf/PUB_FSMB_Trends_in_Physician_Regulation_2006.pdf.

II. INSURING AGAINST INTENTIONAL HARM

A. *Occupational Licensing*

At the theoretical level, 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."[15] Generally, a nongovernmental licensing board is established by the state, with members of the profession, political appointees, and members of the public sitting in review of those desiring admission.[16] 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."[17] Occupational *certification*, for purposes of contrast, implicates the state in the administration of some exam to demonstrate proficiency (which garners certification), even though the profession may be practiced by those both certified and uncertified (e.g. mechanics), whereas occupations requiring a license may *only* be legally performed by those who have met the government's requirements for such status (e.g. physicians).[18]

B. *Medical History*

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.[19] It would not be until 1760, however, that a U.S. jurisdiction (New York City) actually banned the unlicensed practice of medicine.[20] Other cities and states followed this lead, 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.[21] And yet, in the same way, support for the licensing of attorneys waned in the mid-nineteenth century.[22] It is fitting that the momentum for physician licensure slowed during this era because of the period's famously (Jacksonian)

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[15] Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189, 191 (Fall 2000).

[16] FEDERATION OF STATE MEDICAL BOARDS, *supra* note 14, at 14.

[17] Kleiner, *supra* note 15, at 190. *See also* PETERSILIA, *supra* note 5, at 114 (noting that nearly 6,000 occupations are currently licensed in one or more states in the United States).

[18] Kleiner, *supra* note 15, at 191.

[19] 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).

[20] *See* ROBERT DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 1-7 (1969); RICHARD SHRYOCK, MEDICAL LICENSING IN AMERICA, 1650-1965 3-42 (1967); Dolin, *supra* note 19, at 316.

[21] Dolin, *supra* note 19, at 316.

[22] *See* Pinaire et al., *supra* note 12, at 310.

"democratic" leanings[23] and the perception that "licenses"—as opposed to *diplomas*, in the case of doctors—were merely protectionist obstructions to patient choice.[24]

Amidst this (de-)evolution in licensing, 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.[25] While the AMA worked to expand governmental intervention in, and scrutiny of, the practice of medicine throughout the latter half of the 1800s, it was not until the early twentieth century that legislatures throughout the country accepted this charge.[26] By 1925, all state and federal jurisdictions had some versions of a medical practice act.[27] 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.[28] 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.[29] Momentum in this direction was at least consistent with—and perhaps encouraged by—the United States Supreme Court's ruling in *Dent v. West Virginia*, in which the justices deemed an individual's *property* interest (i.e. the right to engage in the profession) insufficient to overcome a conviction by the state for the unlicensed practice of medicine.[30]

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[23] *See* 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, 205 (1999) (noting that regulations passed in the early 1800s were repealed "because of Jacksonian democratic notions of 'every man his own doctor'").

[24] *See* Mitch Altschuler, *The Dental Healthcare Professional Nonresidence Licensing Act: Will it Effectuate the Final Decay of State Discrimination Against Out-of-State Dentists?*, 26 RUTGERS L.J. 187, 192 n.27 (1994); DERBYSHIRE, *supra* note 20, at 6; Jeffrey Lionel Berlant, PROFESSION AND MONOPOLY: A STUDY OF MEDICINE IN THE UNITED STATES AND GREAT BRITAIN 203-216 (1975); LAWRENCE FRIEDMAN, A HISTORY OF AMERICAN LAW 454 (2d ed., Simon & Schuster 1985).

[25] *See* American Medical Association, Illustrated Highlights of AMA History, http://www.ama-assn.org/ama/pub/category/1916.html. (last visited October 18, 2007).

[26] *See* Sue A. Blevins, *The Medical Monopoly: Protecting Consumers or Limiting Competition*, CATO INSTITUTE POLICY ANALYSIS No. 246 (1995), *available at* http://www.cato.org/pubs/pas/pa-246.html; Altschuler, *supra* note 24, at 193; Richards, *supra* note 23.

[27] STANLEY GROSS, OF FOXES AND HEN HOUSES 57-58 (1984).

[28] 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/eLibrary/docs/flexner_report.pdf (follow "external link" for PDF version).

[29] *See* Altschuler, *supra* note 24, at 193.

[30] Dent v. West Virginia, 129 U.S. 114, 123-124 (1889). In this case, the Court accepted

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.[31] It is, however, important to stress that licensure during this era was "concerned with the capacity to deliver minimally adequate care, not with the actual delivery of optimal care."[32] Thus, both the ostensible purposes of licensure and the practices or procedures for procuring a license continued to develop throughout the twentieth century. By 1994, the various licensure examinations in place at that time (e.g., the National Boards, Foreign Medical Graduate Exam in Medical Sciences, and Federation Licensing Exam) were replaced by the United States Medical Licensing Examination (USMLE), an exam that consists of three steps and that is presently required for licensure in all fifty states.[33]

C. *State Medical Boards*

All fifty states, plus the District of Columbia and the U.S. Territories, have medical practice acts in place to define the practice of medicine and to delegate the enforcement of the law to state medical boards, making for a total of seventy state boards authorized to regulate allopathic and/or osteopathic physicians.[34] Typically, such boards handle the licensing of physicians, the investigation of complaints, physician discipline, and, where appropriate, the rehabilitation of offending physicians.[35] Federalism accounts for the variance in regulatory

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the state's argument that individuals lack the expertise to identify competent medical practitioners and thus licensing was appropriate as a mechanism of quality control. *See also* Lawrence v. Board of Registration in Medicine, 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.").

[31] *See* Altschuler, *supra* note 24, at 193; PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 104 (1982).

[32] Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 829 (1995).

[33] *See* Dolin, *supra* note 19, 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 and 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.

[34] *See generally* FEDERATION OF STATE MEDICAL BOARDS, *supra* note 14, at 14.

[35] *Id.* at 14.

structure and discretion of state boards around the country, with some generally independent and others subsumed by larger state agencies (e.g. the Department of Health).[36] Whatever their organization, most boards tend to be composed of physicians who serve as volunteers and members of the general public who were gubernatorial appointees, as well as administrative staff members, executive officers, attorneys, and investigators.[37]

According to the Federation of State Medical Boards, the rationale for such regulatory apparatuses stems from the "potential harm to the public if an incompetent or impaired physician is licensed to practice."[38] As the Florida Supreme Court has stressed, the state interest in regulating doctors is "especially great" in that the physician is in "a position of public trust and responsibility."[39] Thus, state medical boards engage in gate-keeping and supervision for the putative purpose of protecting the public.

In this respect, institutional providers such as hospitals have historically reserved disciplinary authority, although they have been "relatively cautious and ineffective about exercising it, in part because sanctioning hospital physicians requires peers to discipline one another," and thus "'[t]here-but-for-the-grace-of-God-go-I' anxieties tend to run both high and deep in hospitals."[40] A compelling and expanding literature is beginning to address the practice of "policing one's own" in the medical profession.[41] While the focus of such attention extends beyond whether individual colleagues can effectively sit in judgment of one another, the literature addresses the basic capacity for members of the same *profession* to exact the discipline truly necessary to preserve public safety.[42] At

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[36] *See id.* at 21-56 for examples of each state's regulatory structure and board makeup.

[37] *Id.*

[38] *Id.*

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

[40] Frances Miller, *Medical Discipline in the Twenty-First Century: Are Purchasers the Answer?*, 60 LAW & CONTEMP. PROBS. 31, 33 n.15 (1997). *See also* Robert Lowes, *How Groups Discipline Problem Doctors* 72 MED. ECON. 45, 46 (Jan. 9, 1995) (noting a 1992 study that indicated that only 6% of the surveyed group practices had a formal policy for disciplining physicians).

[41] *See* Susan Schentzow, *State Medical Peer Review: High Cost But No Benefit — Is it Time for a Change?*, 25 AM. J.L. & MED. (1999); Phillip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals* 38 U.S.F. L. REV. 301, 305 (2004).

[42] *See, e.g.*, Office of the Inspector General, U.S. Department of Health and Human Services, State Medical Boards and Medical Discipline 7-10 (1990); *LEGAL ISSUES: Washington State Lawmakers Push 'Three Strikes and You're Out' for Doctors*, 2004 HEALTH & MED. WK. 526 (discussing House Bill 2326 which would adopt a "three strikes and you are out" policy for doctors, nurses, and other healthcare providers who commit serious offenses and which would give the state Department of Health the power to conduct investigations and issue sanctions rather than allowing the various professional boards to police their own); Andis Robeznieks, *States Eye Tougher Stance on Discipline, Competency Testing*, 46 AM. MED. NEWS 1 (2003) (discussing legislative bills—and medical society resistance—in Mas-

the same time, though on other fronts, critics accuse state medical boards, as well as the licensing requirements *in and of themselves*, of unfairly inhibiting consumer choice and preserving a "medical monopoly."[43] Conversely, others accuse the boards of regulating too *little* and thus contributing to incidents of medical malpractice.[44]

1. Process

The disciplinary options available to a board will be discussed in more detail in the following section, but typical avenues of recourse might include (a) additional training or education; (b) some manner of service to the community or profession; (c) probationary supervision; (d) license suspension; and (e) license revocation.[45] When discipline *is* instituted by either hospital peer review com-

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sachusetts, New Jersey, Texas, Oregon, and Virginia). *But see* Fred Zeder, *Defending Doctors in Disciplinary Proceedings*, 40 ARIZ. ATT'Y 22, 23 (January 2004) (reminding physicians that "boards have to justify their existence" and suggesting that they do this by "disciplining as many physicians as they can—and by putting some of them out of business.").

[43] Blevins, *supra* note 26, at 1; Ronald Hamowy, *The Early Development of Medical Licensing Laws in the United States*, 1875-1900, 3 J. LIBERTARIAN STUD. 73 (1979). *See generally* PAUL J. FELDSTEIN, HEALTH ASSOCIATIONS AND THE DEMAND FOR LEGISLATION (1977). Critics of licensing boards find them to be anticompetitive and generally monopolistic. They suggest increased composition of these boards of individuals with no vested interest in the medical profession. *See* MILTON FRIEDMAN, CAPITALISM AND FREEDOM 149-60 (1962); Elton Rayack, *Medical Licensure: Social Costs and Social Benefits*, 7 L. & HUM. BEHAV. 155 (1983).

[44] *See* Sidney Wolfe, M.D., *A Free Ride for Bad Doctors*, N.Y. TIMES, Mar. 4, 2003, at A25. *But see* Stephanie Mencimer, LEGAL AFFAIRS, *The White Wall: A New Code of Conduct is Taking Hold of the Medical Profession: First Do No Harm—To Your Colleagues* 65 (2004), *available at* http://www.legalaffairs.org/issues/March-April-2004/story_mencimer_marpar04.html (describing how the North Carolina Medical Board revoked the license of Florida neurosurgeon Dr. Gary Lustgarten following charges that he had given "disparaging, demeaning, or impertinent responses" on the stand and "totally unsubstantiated, inflammatory" testimony about the alleged malpractice of a doctor in the death of a 19-year-old patient in a civil suit for damages brought by the deceased patient's mother. Four years after the case settled out of court, the doctor implicated by Lustgarten filed a complaint with the state board alleging Lustgarten had "testified falsely" at his trial. Following an appeal, a state judge reversed the board on five of six claims and eventually the board revised its ruling to suspension rather than revocation of Lustgarten's license.).

[45] *See infra* Section III; FEDERATION OF STATE MEDICAL BOARDS, *supra* note 14. 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*

mittees or state medical boards, federal law requires that the measures taken be reported to the National Practitioner Data Bank,[46] although other private organizations also act as a kind of clearinghouse for such information.[47]

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 given broad discretion by courts.[48] Moreover, recent legislative changes have granted such boards even greater authority, allowing them to initiate hearings without the receipt of a complaint or a report of a problem-physician.[49] Indeed, rather than constantly revising schemes of regulation pertaining to particular procedures, states have regulated with a "circular process of defining the scope of licensure," whereby state medical licensing laws "avoid defining allowable practice in terms of specific procedures or methods of practice," opting instead to define the practice of medicine more generally.[50] As a result, the role of defining what *is* proper medical practice has effectively been delegated "to medical schools, residency programs, and their private accreditation agencies,"[51] as these are the institutions that actually train one in how to *be* a physician.[52]

2. Populations

Only a small segment of the physician population has been formally disciplined. According to a 1999 Institute of Medicine report, those sanctioned are health care professionals who "may be incompetent, impaired, uncaring, or may even have criminal intent," and thus were properly the subject of investi-

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Practitioner Data Bank? 14 ANNALS HEALTH L. 329, 337-39 (2005); 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 (2003).

[46] 42 U.S.C. §§ 11132-11133 (1994).

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

[48] *See, e.g.*, *In re* License Issued to Zahl, 895 A.2d 437 (N.J. 2006).

[49] *See generally* AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE, (S. Sandy Sanbar et al. eds., 6th ed. 2004). For information on who tends to file complaints and initiate reports to medical boards—as well as the nature (non-clinical as it may often be) of such complaints—see Timothy S. Jost et al., *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 HEALTH MATRIX 309 (1993).

[50] Richards, *supra* note 23, at 211.

[51] *Id.*

[52] Brian Bromberger, *Rehabilitation and Occupational Licensing: A Conflict of Interests*, 13 WM. & MARY L. REV. 794, 812 (1972) (stressing that legislative and judicial institutions "should not permit subordinate agencies to exercise power and discretion above that which is needed for the efficient accomplishment of their established purpose").

gation and/or action in order to protect patients from harm.[53] On a national scale, disciplinary actions were imposed upon approximately .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.[54]

Within this sub-class of offenders, however, we see further correlations that shed light on the profile of doctors who tend to receive sanctions. One recent study of 890 physicians disciplined by the Medical Board of California from 1998-2001 found an association between various physician characteristics and the likelihood of medical board-imposed discipline.[55] Specifically, the investigators of this study found that certain specialties (e.g., obstetrics and gynecology, general practice, psychiatry, and family practice) were more likely to be disciplined than those in others (e.g., pediatrics and radiology).[56] Moreover, this study concluded that there is a positive association between age and discipline, meaning that physicians in practice for longer than twenty years were more likely to have been disciplined.[57] However, the researchers concede 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.[58] In addition, international medical graduates were "significantly more likely to be disciplined than domestic graduates."[59]

Another study of 235 graduates, coming from three medical schools, who were disciplined by one of forty state medical boards between 1990 and 2003 found that disciplinary action by state boards was strongly associated with prior unprofessional behavior in medical school.[60] This behavior encompasses both "severe irresponsibility" and "severely diminished capacity for self-improvement" and, to a lesser degree, lower MCAT scores and poor grades during the

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[53] TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 169 (LINDA T. KOHN et al. eds., 2000).

[54] *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.

[55] *See* Neal D. Kohatsu, M.D. et al., *Characteristics Associated with Physician Discipline*, 164 ARCHIVES OF INTERNAL MED. 653 (2004).

[56] *Id.* at 656.

[57] *Id.*

[58] *Id. See also* James Morrison and Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1891 (1998) (also 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).

[59] Kohatsu et al., *supra* note 55, at 656.

[60] Maxine A. Papadakis, M.D., et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 NEW ENG. J. MED. 2673, 2676 (2005).

first two years of medical school.[61] At the same time, board certification is consistently associated with a *lower* risk of discipline, suggesting that this standard might properly be considered "one benchmark of clinical quality, whether as a direct measure of specialty-relevant knowledge and skills, or as a visible indicator for other characteristics associated with good medical practice."[62] In this light then, medical boards by and large appear to be serving their basic purpose.

III. BAD MEDICINE: DISCIPLINING NEW JERSEY DOCTORS

Before turning to the specific data, it is important to summarize how New Jersey's medical licensing system works. New Jersey has required licenses to practice medicine for over one hundred years.[63] The State's Board of Medical Examiners (BME) was created by the Legislature in 1894 and is part of the Department of Law and Public Safety's Division of Consumer Affairs.[64] Its twenty-one members include twelve physicians, one podiatrist, three members of the public, a certified nurse midwife, a licensed physician assistant, one bioanalytic laboratory director, a government liaison member, and the Commissioner of Health or his designee.[65] The BME is responsible for licensing and disciplining physicians, as well as for keeping the public safe and informed.[66]

A. *The Disciplinary Process*

The BME learns when a doctor has committed an offense in various ways: from the doctor him or herself,[67] the doctor's employees, insurance companies, courts, and the media.[68] Disciplinary proceedings against doctors generally begin with a preliminary hearing before a BME subcommittee, called the Preliminary Evaluation Committee.[69] This subcommittee listens to the doctor's testi-

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[61] *Id.* (noting that examples of "irresponsibility" include unreliable attendance at clinic, while a "diminished capacity for self-improvement" would include an inability to accept constructive criticism).

[62] Kohatsu et al., *supra* note 55, at 657.

[63] *See* NEW JERSEY DIVISION OF CONSUMER AFFAIRS, STATE BOARD OF MEDICAL EXAMINERS, BOARD HISTORY, http://www.state.nj.us/oag/ca/bme/board/history.htm.

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] For some suggestive data on the rates of physician non-reporting of their criminal histories see MEREDITH LARSON, BENITA MARCUS, PETER LURIE & SIDNEY WOLFE, 2006 REPORT OF DOCTOR DISCIPLINARY INFORMATION ON STATE WEB SITES (2006), http://www.citizen.org/documents/1791MedBoard2006FullReportWeb.pdf.

[68] Since this process is not a perfect one, doctors can slip through the cracks. See Pinaire et al., *supra* note 12, at 326 for a description of this process in the similar case of attorneys.

[69] Note that we are simply presenting a summary of the process. There are many exceptions that we see no need to elaborate on here. While the Preliminary Evaluation Committee reviews the bulk of BME disciplinary cases, more specific cases may begin elsewhere. For

mony and reviews and categorizes every complaint, determining which cases are "no cause" (where no offense was committed), which involve patient harm (and therefore must be expedited), and so on.[70] The subcommittee will subsequently report those cases where an offense has been committed to the full BME and offer recommendations as to how to proceed with each case.[71] After deliberation, the BME will make recommendations to the Attorney General's (AG) office, which represents the BME, as to how the AG should proceed.[72]

The AG's office utilizes two deputy attorney generals (DAG) to represent the BME in disciplinary proceedings—one counseling the BME and the other prosecuting on behalf of the BME.[73] The DAG responsible for a given case negotiates settlements with the doctor's defense attorney but cannot make a final decision without the approval of the BME.[74] The relationship between the BME and the AG's office is like that of all attorney-client relationships: the DAG negotiates at his or her client's direction and is constrained by the BME's directives in during negotiations.[75] The DAG can only make recommendations to the BME regarding the BME's options and what the DAG will be able to successfully prove.[76] After receiving instructions from the BME as to whether the case should be settled or a formal complaint should be filed, the DAG meets with the defense attorney and proceeds from there.[77] At this point, most

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example, cases which need to be moved quickly—i.e. those where the doctor poses an immediate danger to the public—are evaluated by a Priority Review Committee. In addition, malpractice cases may be brought before the Medical Practitioner Review Panel, which, unlike the Preliminary Evaluation and the Priority Review Committees, is a standing panel consisting of nine members—eight appointed by the governor and one who is a member of the BME appointed by the president of the BME. N.J. STAT. ANN. §§ 45:9-19.8 (West 2004), *available at* www.NJConsumerAffairs.gov (last visited Apr. 10, 2007). Moreover, not all cases begin with a hearing before a subcommittee—some very serious cases may be brought directly before the full BME.

[70] Division of Consumer Affairs, State Board of Medical Examiners, Statutes and Regulations (2006), 46-47, *available at* http://www.state.nj.us/lps/ca/bme/bmelaws.pdf.

[71] *Id.*

[72] *Id.*

[73] Interview #2, New Jersey state official, Office of the Attorney General (Jan. 11, 2005). It has been argued that the relationship between the AG and the BME is incestuous by nature because each case has two DAGs—a situation that would be considered unusual anywhere else. On the other hand, the DAGs call the separation between the AG and the BME the "Wall of China," because they do not discuss cases with each other and their activities come into play at different stages of the case. To illustrate, the counseling DAG will make recommendations to the BME as to how it should proceed in a given case and the BME will then tell the prosecuting DAG how to handle the case. Interview #5, New Jersey defense attorney (May 23, 2006).

[74] Interview #6, New Jersey defense attorney (May 24, 2006).

[75] *Id.*

[76] *Id.*

[77] *Id.*

cases are settled—only a slight percentage of cases result in formal complaints.[78]

If a formal complaint has been lodged, then there will be a hearing.[79] The BME has the choice of holding the hearing either before the full BME or the Office of Administrative Law's (OAL) Administrative Law Judge (ALJ).[80] Since these hearings take a substantial amount of time and the BME meets only once a month, the BME usually decides to hear those cases which it thinks can be moved quickly or will be settled.[81] When the hearing is held before the ALJ, the ALJ issues an initial decision—essentially no more than a recommendation—to the BME, which then reaches a final decision.[82] The BME's action becomes permanent public record in a Formal Order.[83] However, the practitioner has a right to appeal this decision to the Appellate Division of the Superior Court and, ultimately, to the state Supreme Court.[84]

B. *Processing Felony Charges*

There are two departments in New Jersey that deal with doctors who have committed felonies: the Division of Criminal Justice (DCJ) and the Division of Insurance Fraud (DIF). The DCJ has prosecutorial power and can bring its own cases.[85] The DIF has both civil and criminal authority, DAGs, and investigators, and is responsible for the bulk of insurance fraud cases.[86] Insurance companies are required to report to the DIF if they find unusual activities in the doctor's patient records.[87] The DIF, in turn, is required to report any action taken against doctors to the BME.[88] If a case is not serious, the DIF will offer the doctor a civil settlement, but, if it is serious, the DIF may use appropriate criminal sanctions.[89] The DIF is not directly concerned with licensure except to the extent that it must report violations to the BME. In cases involving what might be called global resolutions, however, our respondents noted that a doc-

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[78] *Id.*; Interview #4, New Jersey state official, Office of the Attorney General (May 17, 2006).

[79] Interview #2, *supra* note 73.

[80] *Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.* Unless a temporary sanction has been issued, the public is unaware of Board activities until this point. The investigatory stage of physician discipline is confidential and those sections of BME meetings involving the investigation are closed to the public.

[84] *Id.* It is important to note that our presentation of the physician disciplinary process is a general sketch; it suffices for this paper, however, because we are focusing on the final results rather than on the intricacies of the disciplinary process.

[85] Interview #6, *supra* note 74.

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *Id.*

tor may refuse a DIF settlement offer because of an inability to receive a satisfactory offer at the BME stage[90]. This will be explained in greater detail below.

In those instances where a case is first tried by criminal authorities, the BME will not necessarily hold off on the disciplinary hearing until the criminal trial is over. The BME will weigh its desire not to harm the criminal case against the necessity to protect the public.[91] In order to achieve both, the BME will offer the doctor the option of voluntarily surrendering his/her license until the trial is over.[92] If the doctor refuses this option, the disciplinary proceedings will be instituted simultaneously with the criminal trial.[93] Thus, it seems to be in the doctor's best interest to surrender his or her license "voluntarily," because whatever is said in the disciplinary hearing can be used by the prosecutor in the criminal case.[94] If, however, the doctor invokes the Fifth Amendment privilege against self-incrimination, the BME will wait until the criminal case has concluded before starting disciplinary proceedings.[95] This way nothing the doctor says in the BME hearings can be self-incriminating. If the doctor is acquitted, double jeopardy protects the doctor from ever being tried again in a criminal court for the same alleged criminal activities.[96] Yet, even if a doctor is acquitted in the criminal trial, he or she may still be disciplined by the BME due to its "preponderance of evidence" standard.[97] Conversely, where there has been a criminal conviction, action can be taken by the BME without a disciplinary hearing.[98] In fact, while final action does require a hearing, criminal cases

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[90] *See supra* Part III.A.

[91] Interview #4, *supra* note 78.

[92] *Id.*

[93] *See* State v. Kobrin Securities, Inc., 544 A.2d 833, 837 (N.J. 1988) (holding that "when relief is sought to prevent continued injury to the public . . . the civil proceedings should not be stayed except in the most unusual circumstances.").

[94] *See In re* Burke, No. A-5030-04T1, 2006 WL 3434832, at *1 (N.J. Super. A.D. Nov. 30, 2006) (Supporting the use of testimony in administrative proceedings, the Appellate Division of the Superior Court of New Jersey ruled that "considering the important public interests at issue, it was not a violation of due process to proceed administratively against the doctor despite the ongoing criminal investigation . . . There was no constitutional barrier precluding Dr. Burke from being required to choose whether to testify in the administrative proceedings or invoke the Fifth Amendment, even though providing testimony may have aided the ongoing criminal investigation.").

[95] Interview #4, *supra* note 78.

[96] U.S. CONST. amend. V.

[97] *See In re* Polk, 449 A.2d 7, 15 (N.J. 1982) (The New Jersey Supreme Court ruled that the "preponderance of evidence" standard of proof in medical disciplinary proceedings "constitutes an appropriate level of certainty to establish guilt [and] does not create an unreasonable risk of mistake.").

[98] *See In re* Fanelli, 803 A.2d 1146, 1152 (N.J. 2002) (The New Jersey Supreme Court held that "because [a doctor's] license is subject to revocation . . . he must be afforded the opportunity to have a hearing conducted" on the issue of the appropriate sanction; a criminal conviction itself is not enough to prove moral turpitude.).

involving doctors are referred to as "paper cases" since they can usually be moved quickly.[99]

IV. A CLINICAL INVESTIGATION

A. *Interview Data*

Our interviews with legal and political elites were illuminating in two senses: first, and most predictably, we learned an enormous amount about the "law in action" vis á vis medical infractions, and second, our triangulation of methods (interpretive analysis, in-depth interviews, and coding/categorization)[100] meant that the interviews had the distinct value of bringing our quantitative data to life. Specifically, these interviews (1) helped us code the data, (2) validated our hope that these data really captured the process, (3) suggested ways that the data could miss some critical elements of the disciplinary process, and (4) helped us to tease out implications of the often chaotic data.

As will be noted, we obtained the data by arduously coding the summaries of BME disciplinary hearings, often observing the incompleteness of the provided summaries and the opaqueness of the data.[101] We found the respondents' input regarding our interpretation of this data invaluable–sometimes this was nothing more than being reassured that what was unclear in the data was in fact unclear, or simply that what we did not know was in fact generally unknowable. It was encouraging for us to learn that seeming contradictions in the data were in fact genuine contradictions in the way the BME coded cases.[102] We were also struck by the respondents' eagerness to see aggregated what they had only seen in individual cases prior to our data collection. Indeed, their reflections on our data contributed to our own analysis of their data.

B. *Quantitative Data*

The minutes from the BME's monthly meetings were used to summarize

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[99] Interview #2, *supra* note 73. However, not all criminal cases involving doctors are easily processed. If a doctor has not made any concessions on the record, even when a doctor has been found guilty by a criminal court as in those cases involving nolo contendre pleas, this doctor may avoid discipline or receive lesser discipline from the BME. This will happen in cases where the DAG does not have sufficient evidence separate from the criminal trial to prove its case.

[100] *See* MICHAEL MCCANN, RIGHTS AT WORK: PAY EQUITY REFORM AND THE POLITICS OF LEGAL MOBILIZATION 16 (University of Chicago Press 1994) (discussing the values of "triangulation").

[101] We were fortunate to observe the process up close when attending a BME meeting. At this meeting we witnessed the integral role played by involved DAGs, which was an important component of the paper record examined for most doctor data.

[102] Often the BME will code sanctions using different terminology, but the punishment will actually be the same (e.g. stayed suspension and probation).

each disciplinary action taken in 2000 and from 2002 to 2005.[103] After we completed this task, we aggregated the individual actions into summary statistics by sanction and offense. These constitute a unique data set as there are simply no specific data of this sort available.[104] More general data, however, do exist. For example, Public Citizen's Health Research Group (HRG), founded by Ralph Nader, provides general information and state-by-state comparisons of medical boards.[105] The HRG has compiled names of disciplined doctors, first in books and then on their website,[106] both of which are no longer available. Moreover, a recently published HRG study describing sanctions for physician criminal offenses begins by pointing out that there are no systematic studies on the very topic we tackle in our data.[107] This study, however, attempted to analyze the sanctioning of physicians who committed felonies between 1990 and 1999.[108] Their authors relied on existing data sets and necessarily painted with a broad brush.[109] It also appears that their primary purpose was different than ours—namely, to explain the variables associated with criminal behavior of physicians.[110] Interestingly, their research yielded some findings consistent with our recent and more in-depth study. Most notably, the HRG authors share our conclusion about the surprisingly lenient treatment of physicians who commit felonies in many areas and the opportunities for physicians convicted in one state to resume their medical activities in another.[111] Significantly however, HRG has not conducted an in-depth study of the internal methods, mechanisms, and machinations within individual states that we present in this article (other than data-reporting forums).[112]

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[103] Unfortunately, despite repeated requests, we were not provided with the summary of Board's 2001 actions.

[104] There is good news and bad news about the New Jersey data as used in this study. The good news is that the N.J. data are richer in the information they provide regarding the nature of the offender, other state actions, and so on, than are the data of other states. *See* LARSON et al., *supra* note 67. The bad news, however, is that, as suggested in the text, the rich data provided on individual physicians is simply not aggregated, and therefore required the kind of data collection efforts that we undertook in this paper.

[105] *See* MEREDITH LARSON, BENITA MARCUS, PETER LURIE, M.D., MPH & SIDNEY WOLFE, M.D., PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, REPORT OF DOCTOR DISCIPLINARY INFORMATION ON STATE WEB SITES (October 17, 2006), http://www.citizen.org/documents/1791MedBoard2006FullReportWeb.pdf).

[106] *See* Public Citizen's Health Research Group, http://www.citizen.org/hrg// (last visited Sept. 27, 2007).

[107] *See* Paul Jung, Peter Lurie & Sidney Wolfe, *U.S. Physicians Disciplined for Criminal Activity,* 16 HEALTH MATRIX 335 (Summer 2006), *available at* http://www.citizen.org/publications/release.cfm?ID=7454.

[108] *Id.* at 337.

[109] *Id.* at 337-338.

[110] *Id.* at 336-37.

[111] *Id.* at 344.

[112] Another source of data on physician disciplinary actions is the National Practitioner

Our data, then, are far more robust than other available data, although it should be noted there are also limitations. Cases in which the BME took no action or entered into a "private settlement"[113] with the defendant are *not* included in the data. In addition, note that the data for the year 2001 are missing. Moreover, gathering data from the BME was a difficult and time-consuming process,[114] notably different from the process of analyzing the more straightforward data provided by New Jersey's Office of Attorney Ethics.[115] The BME data are incomplete and difficult to sift through due to the use of convoluted language. The data are also opaque and confusing, as many references lack necessary explanation.[116] Cumulatively, the data are what social scientists might refer to as "noisy" (or what the uninitiated might see simply as a "mess")—sifting through the data and culling the relevant BME actions was no simple matter. That said, we are confident we have obtained a generally accurate record of final dispositions against physicians.[117]

V. OPERATING WITHOUT A LICENSE

A. *Offenses*

Since many doctors committed multiple offenses, for organizational purposes we only attributed to doctors the single most "serious" offense they committed.[118] Professional offenses are considered least serious, followed by offenses implicating the doctor's psychological state, Controlled Dangerous Substances (CDS)-related offenses, offenses related to sexual deviance, drug-related offenses, violent offenses, offenses in which the doctor exhibited fraudulent behavior, and, most serious—at the very least because of the core threat

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Data Bank (NPDB). State medical boards are required to report disciplinary actions to the NPDB but only the most cursory data are provided and information on specific physicians is not available to the general public. *See* NPDB Home Page, *available at* http://www.npdb-hipdb.com/index.html (last visited Dec. 12, 2007).

[113] This is an important finding to be discussed below in more detail. *See infra* Part VI.B.

[114] A recurring theme of our interviews was the perception that the BME purposely makes it difficult to collect these data and provides as little information as possible. Despite these obstacles, our data were considered impressive by our respondents, many of whom were eager to look through them and claimed that ours was a unique data set in N.J.

[115] Pinaire et al., *supra* note 12.

[116] For example, there are several instances where the offense for which the doctor is being disciplined is not specified.

[117] On balance, our data are clearly better than other publicly available data, yielding a satisfactory summary of BME actions, and successfully passing the filter of several of our respondents with whom we shared this data. Respondents were intrigued both by descriptions of individual cases and by the summary data presented in charts and tables.

[118] This process of coding offenses was itself an arduous task, requiring repeated inter-coder reliability checks were used to ensure reliability.

to the very essence of professional integrity—insurance fraud.[119] Moreover, as our article is primarily concerned with Board imposed sanctions for doctors who committed felonies, our findings only include final actions taken by the BME against physicians, thus excluding temporary actions and actions imposed upon anyone other than doctors (e.g. unlicensed individuals, athletic trainers, nurses).

Consequently, out of 135 actions taken by the BME in 2000, only eighty-two were used in this article; out of 149 in 2002, 102 were used; out of 142 in 2003, seventy-nine were used; out of 133 in 2004, seventy-three were used; and out of 115 in 2005, sixty-one were used. (See Table 1) It should also be noted that in the overall presentation we begin by looking at *all* final disciplinary actions taken against doctors. Later, we will examine only cases involving felonies. We include all actions initially because we think that the dispositions in these cases contribute to the impression respondents have about the severity, or lack thereof, of the BME's sanctioning doctors.

TABLE 1: TOTAL NUMBER OF OFFENSES PER YEAR

Nature of Offense	2000	2002	2003	2004	2005	Total
Unknown	0	4	4	1	1	10 (2.5%)
Professional	23	35	32	28	26	144 (36.3%)
Psychological Disorder/Illness	2	2	2	2	0	8 (2.0%)
CDS-related	9	3	6	5	5	28 (7.1%)
Sex-related	9	10	8	4	5	36 (9.1%)
Drug-related	10	11	4	11	6	42 (10.6%)
Violent	0	3	1	1	2	7 (1.8%)
Fraudulent Behavior	19	19	14	16	6	74 (18.6%)
Insurance Fraud	10	15	8	5	10	48 (12.1%)
Total	**82**	**102**	**79**	**73**	**61**	**397**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

It is difficult to state conclusively how many doctors committed felonies. While in some cases the BME summaries state that doctors were indicted, there are many instances where we can only assume that a felony was committed.[120]

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[119] For a discussion of what is included in these categories, see the Appendix.

[120] The NJ Division of Consumer Affairs operates the N.J. Health Care Profile as mandated by the New Jersey Health Care Consumer Information Act which became effective in June 2004. N.J. STAT. ANN. § 45:9-22.21 (West 2004). The Profile, among other information, includes disciplinary actions taken against doctors as well as convictions of first through fourth degree crimes from the last ten years. Licensees are required to provide this information and to update their profiles—if they do not they may be subject to disciplinary action. However, the Profile is not completely accurate or inclusive as the authors of this

Thus, although sex-related offenses, drug-related offenses, offenses involving fraudulent behavior, and insurance fraud are by and large felony offenses, many of the cases may not have been charged as felonies. Moreover, there can be instances of felonies in any of our other categories—including professional offenses, CDS-related offenses, and offenses committed due to psychological problems or illness.

TABLE 2: SANCTIONS FOR FELONY OFFENSES

Sanction	Sex-related Offenses	Drug-related Offenses	Violent Offenses	Fraudulent Behavior	Insurance Fraud	Total
Revocation	15	5	3	28	15	66 (32%)
Surrender	3	21	0	2	5	31 (15%)
Indefinite Suspension	4	9	3	6	6	28 (14%)
Suspension (more than one year)	3	2	0	3	3	11 (5%)
Suspension (one year or less)	4	1	0	12	6	23 (11%)
Probation (more than one year)	4	1	0	5	1	11 (5%)
Probation (one year or less)	1	1	1	5	2	10 (4%)
Reprimand	2	1	0	13	7	23 (11%)
Restrictions/Conditions	0	1	0	0	3	4 (2%)
Total	**36**	**42**	**7**	**74**	**48**	**207**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

For purposes of this article, however, we made the assumption that most drug-related, sex-related, and violent offenses are felonies, as well as those offenses where the doctor exhibited fraudulent behavior and offenses involving insurance fraud. Thus, as Table 1 demonstrates, of the 397 Board actions under consideration, 207 were considered felonies. Working under this assumption, Table 2 indicates that, of those offenses involving drugs, sex, violence, fraudulent behavior, and insurance fraud, thirty-two percent of these cases resulted in revocations, fifteen percent resulted in license surrenders, fourteen percent resulted in indefinite suspensions, and five percent resulted in suspensions of

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paper learned first-hand after searching for several licensees who have been disciplined by the BME as well as convicted of crimes and finding that some of this information was missing from the respective physicians' profiles. In fact, the Division of Consumer Affairs posts a disclaimer which states: "Information within individual profiles comes from a number of sources, and the Division cannot and *does not* guarantee its accuracy." (emphasis in original). *See* NEW JERSEY OFFICE OF THE ATTORNEY GENERAL, DIVISION OF CONSUMER AFFAIRS, GENERAL DISCLAIMER STATEMENT, http://12.150.185.184/dca/disclaimer.jsp (last visited Dec. 3, 2007).

over one year—thus, *sixty-six percent of cases where felonies were committed resulted in sanctions ranging from one year suspensions to revocations.*[121]

B. *Sanctions*

With these factors in mind, we now turn to a more detailed examination of the sanctions meted out by the BME.

1. Revocations

Unlike the permanent disbarment we found in the case of attorneys,[122] there is no *de jure* "permanent" punishment for doctors.[123] It is the case, however, as we learned from our interviews, that while most doctors *can* reapply to get revoked licenses back, most do not, making for a *de facto* permanence to the sanction.[124] This notwithstanding, it is important to stress that while most doctors who have had licenses revoked do not in fact reapply, in theory they could at any time—meaning that a revocation could, ironically, amount to a shorter period of license denial than that faced by a doctor who has simply had her license *suspended* for a specified period of time.[125]

2. Voluntary Surrender

Doctors undergoing BME scrutiny have the option of voluntarily surrendering their licenses.[126] Doctors often choose to voluntarily surrender their license without waiting for the final disposition of the BME when they know they face a relatively severe punishment.[127] The major incentive in these cases is to avoid paying the fees and penalties stemming from lengthy formal action by the BME. Thus, "voluntary" surrenders are not always completely voluntary; indeed, as noted, the BME may actually *order* the doctor to "voluntarily" surrender his or her license. The duration of such a surrender varies from a relatively short time (equivalent to a short-term suspension) to an indefinite period of time.[128] In addition, the BME often specifies whether it will place obstacles in

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[121] We will argue below that these data need to be viewed differently: namely, without including reciprocal actions (i.e. actions taken by other states).

[122] *See In re* Wilson, 409 A.2d 1153, 1157 n.5 (N.J. 1979).

[123] While revocations should be counted amongst the most serious sanctions, indefinite suspension may be worse. As will be shown below, unless otherwise specified, a doctor can reapply for his or her revoked license immediately, whereas a doctor with a suspended license must wait for the period of suspension to end before being able to reapply.

[124] Interview #5, *supra* note 73. This is also a matter that will be discussed in more detail below.

[125] *Id.*; Interview #11, New Jersey state official, Office of the Attorney General (Nov. 7, 2007).

[126] Interview #5, *supra* note 73.

[127] *Id.*

[128] Interview #4, *supra* note 78.

the path of re-licensure by stating whether the doctor's voluntary surrender is with or without prejudice to reapplication.[129]

3. Suspension / Probation

BME sanctions may also take the form of either a probationary period or a suspension (generally for a specificied amount of time), though there appear to be multiple variations within these categories of sanction.[130] Examination of BME disciplinary actions reveals that BME sanctions are not models of specification and clarity. Again, adding to coding difficulties, there is a proliferation of terms associated with seemingly similar punishments stemming from instances in which one offense is wrongly classified or a different punishment is served than the one originally ordered. A further example of confusing jargon in dispositions is a punishment labeled "inactive stayed suspension," under which doctors can practice conditionally, as though under probation.[131] Conditions that are used include: (a) the successful completion of ethics and/or other related courses; (b) chaperones for client contacts paid for by the physician (a fascinating component of physician related probation we will discuss in more detail below); (c) therapists/counseling (e.g. "boundary counseling" in cases involving a doctor who has had sexual relations with a patient, voluntarily or not[132]); and (d) monitoring by designees of the BME of patient records, finances, the general practice, and so on.[133] For purposes of this paper, we chose a simple "truth in sentencing" coding scheme.[134] When a sanction was stayed to be served as something else (as in the case of inactive suspension), we overlooked the conditions frequently attached to a basic probation sentence, as well as the opaque and confusing language previously mentioned.

4. Reprimands / Minor Sanctions

These sanctions are relatively minor slaps on the wrist when viewed in the range of BME sanctions, but they can have significant consequences for the physician in obtaining insurance or receiving insurance payments in the future.[135] Moreover, they become part of the doctor's permanent record.[136]

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[129] *Id.* As noted above, voluntary surrenders deemed revocations by the BME were counted as revocations for purposes of this paper.

[130] Interview #2, *supra* note 73.

[131] Interview #4, *supra* note 78.

[132] Doctors are prohibited from having sex with their patients, even if it is voluntary, because of the unique nature of the doctor-patient relationship.

[133] Interview #6, *supra* note 74.

[134] *See* JAMES AUSTIN & JOHN IRWIN, IT'S ABOUT TIME: AMERICA'S IMPRISONMENT BINGE 20, 225, 241 (3d ed. 2001); Alan M. Dershowitz, *Background Paper from Fair and Certain Punishment: Report of the Twentieth Century Fund Task Force on Criminal Sentencing* 79-80 (1976), in CASES AND MATERIALS ON THE LAW OF SENTENCING, CORRECTIONS, AND PRISONERS' RIGHTS 155-56 (Lynn S. Branham ed., 6th ed. 2002).

[135] Interview #2, *supra* note 73.

5. Professional Assistance Program

We learned from the interviews that one significant action the BME may take in disciplining doctors is placing the doctor into the Professional Assistance Program (PAP—formerly the Physician's Health Program) as a component of discipline. Doctors may also enroll in the PAP independently, for the PAP is, in itself, significant in providing an alternative to standard sanctions. The PAP is a program that attempts to help doctors suffering from psychiatric disorders, disruptive disorders, psycho-sexual disorders, cognitive and physical impairment, and abuse of alcohol and drugs by evaluating their disorder, providing treatment, and monitoring the treatment.[137]

Most notably, the PAP manages the Alternative Resolution Program (ARP), which allows impaired doctors to be treated anonymously as an alternative to BME discipline.[138] The ARP is administered by the Impairment Review Committee (IRC), which was established by the BME and is made up of five physicians: two members of the BME, two members of the PAP, and one member who is appointed by the Commissioner of Health.[139] There are ninety doctors participating in the ARP in an average year, with treatment spanning five years or more.[140] When doctors seek treatment from the PAP each case goes through the IRC, which determines whether the doctor in question should be placed in the ARP.[141] The names of doctors in the ARP are withheld from the BME unless the doctor relapses[142] or the IRC decides that the doctor's problem is so egregious that the BME needs to get involved.[143] It should be noted that the ARP treats and counsels impaired doctors, while the BME is responsible for

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[136] Interview #5, *supra* note 73.

[137] Interview #6, *supra* note 74.

[138] Interview #7, staff member of the Professional Assistance Program, New Jersey State Board of Medical Examiners (Dec. 26, 2006).

[139] N.J. BD. MED. EXAMINERS STAT. & REG. §§ 13:35-11.2, *available at* www.NJConsumerAffairs.gov.

[140] Interview #7, *supra* note 138.

[141] The IRC makes this determination after reviewing a report provided by the PAP describing the nature of the impairment, whether patients were harmed as a result of the impairment, whether the physician practiced while impaired, if the physician could be criminally penalized as a result of the impairment, and any prior rehabilitative programs in which the physician may have previously participated. In addition, the report includes a proposed treatment plan. *Id.* It should be noted that the PAP only provides the IRC with the licensee's code number, thereby withholding the identity of the physician. N.J. BD. MED. EXAMINERS STAT. & REG. §§ 13:35-11.3. However, when physicians are referred to the IRC by entities other than the PAP, such as the physician him or herself, the BME, or the physician's colleagues, their identities are disclosed. Interview #7, *supra* note 138.

[142] Interview #7, *supra* note 138. A doctor may be allowed to remain in the ARP despite relapse if the IRC determines it would be acceptable with additional monitoring and counseling. Otherwise, the doctor will be referred to the BME for a public order of discipline.

[143] *Id.*

dealing with legal issues.[144] The ARP, respondents informed us, can be viewed as a "therapeutic" version of Pre-Trial Intervention.

VI. PRESCRIBING JUSTICE

In the process of generating quantitative and qualitative data, the basic picture that emerged is one of a lack of severity on the part of the BME. Indeed, over the course of conducting interviews we repeatedly encountered the notion that doctors are not severe in punishing fellow doctors. Considering all final dispositions, revocations are rarely used and over one-third of revocations are in fact the result of previous sister-state actions, as are the majority of indefinite suspensions. (See Table 3) Cutting the other way, however, it should be noted that when felonies alone are considered, free of reciprocal actions (see Table 4), the majority of New Jersey-licensed doctors who have committed felonies *do* indeed receive more serious punishment (revocations, surrender, indefinite suspensions, and suspensions of over one year). This is the case in sixty-seven percent of cases. In this sense, then, the perception of a lack of severity is not reflected in the quantitative data relating to New Jersey by itself.

TABLE 3: TOTAL NUMBER OF SANCTIONS (2000, 2002-2005)

Sanction	Non-Reciprocal Actions	Reciprocal Actions	Total
Revocation	55	30	85
Surrender	46	13	59
Indefinite Suspension	16	36	52
Suspension (more than one year)	16	2	18
Suspension (one year or less)	33	9	42
Probation (more than one year)	14	17	31
Probation (one year or less)	11	1	12
Reprimand	70	11	81
Restrictions/Conditions	14	3	17
Total	**275**	**122**	**397**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

In addition, we should stress that even the most seemingly lenient punishments can be rather serious. These punishments become part of the public record[145] and previous discipline is considered if the doctor once again finds him

[144] *Id.* However, if the offense committed by the doctor was a direct result of the doctor's diagnosis, the doctor may be able to bypass Board discipline and enter treatment with the ARP directly.

[145] Interview #5, *supra* note 73. Additionally, the very fact that a doctor has been disci-

TABLE 4: SANCTIONS FOR FELONY OFFENSES (EXCLUDING RECIPROCAL ACTIONS)

Sanction	Sex-related Offenses	Drug-related Offenses	Violent Offenses	Fraudulent Behavior	Insurance Fraud	Total
Revocation	10	3	1	16	9	39 (35%)
Surrender	2	19	0	1	3	25 (22%)
Indefinite Suspension	0	1	1	1	1	4 (4%)
Suspension (more than one year)	2	1	0	2	2	7 (6%)
Suspension (one year or less)	3	1	0	4	5	13 (12%)
Probation (more than one year)	0	0	0	2	1	3 (3%)
Probation (one year or less)	1	1	1	2	0	5 (5%)
Reprimand	1	0	0	6	5	12 (11%)
Restrictions/ Conditions	0	1	0	0	3	4 (4%)
Total	**19**	**27**	**3**	**34**	**29**	**112**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

or herself involved in a disciplinary proceeding.[146] Finally, although the medical quantitative data suggest greater severity than our interview data suggests, the bottom line is complex. Sanctioning of doctors for felonies is more severe in New Jersey than participants perceive it to be *but* not as severe as it is for attorneys in the Garden State.[147] As suggested above, this picture of leniency results from the fact that these data include the sanctioning of doctors for offenses other than felonies as well as for offenses first disciplined in another state. The latter is discussed in more detail below as are other explanations for the perception of leniency. This is a complicated and important way of understanding sanctioning against physicians in New Jersey. We conclude then that the perception of leniency on the part of the BME stems from four factors: the lack of permanent sanctions; the existence of private settlements; the practice of plea-bargaining; and the extensive use of reciprocity.

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plined may mean that he or she is no longer eligible as a carrier of federally funded insurance programs—this is in itself a collateral consequence that can be devastating to a doctor's career.

[146] *Id.*

[147] From 2000 to 2003, seventy-two percent of attorneys who committed felonies were either involuntarily disbarred or consented to disbarment and in New Jersey disbarment is always permanent. *See* Pinaire et al., *supra* note 12, at 318.

A. *Absence of Permanent Sanctions:*

A significant factor contributing to the perception of leniency in physician discipline is that no sanctions are "permanent." As already stated, whereas disbarment of attorneys is *always* permanent, revocation of doctors' licenses is not.[148] Indeed, most doctors who do reapply get their licenses reinstated; *however*, it is also the case, as we noted before, that most doctors do not reapply.[149] It is telling that of the eighty-two doctors disciplined in 2000—all of whom *could* have reapplied within the following five years—only fourteen did within the years under examination,[150] but of that group almost all (twelve) were issued some form of reinstatement. (See Table 5)

Again examining the data in Table 5, of the 102 doctors disciplined in 2002 only twenty had reapplied by 2005, and *all twenty* received some form of reinstatement. Looking at the complete data set, the BME considered only 113 applications for some degree of licensure out of 674 total Board actions taken during the five years with which we are concerned.[151] Of these, as Table 6 shows, fifty-six percent resulted in unrestricted licensure, thirty-seven percent resulted in limited reinstatements, and only seven percent resulted in denials of reinstatement. Moreover, while the eight denials were issued to doctors who committed what would be considered felonies,[152] the Board issued some form of reinstatement in the remaining eighty-nine percent of cases where the doctor had originally been disciplined for a felony.

The reasons for why doctors may not reapply vary and dissuade us from reaching too facile a conclusion about the effects of surrendering one's license. For one thing, doctors may be pessimistic about the outcome.[153] Second, doctors may be licensed in another state and thus feel that there is no need to get

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[148] *See supra* Part V.B.1.

[149] Interview #6, *supra* note 74. It should be noted here that not all doctors who are disciplined have to reapply—reinstatement is automatic in some cases. This is dependent on whether or not the final order of discipline explicitly states that the doctor must appear before the Board before resuming practice. Of course, doctors whose licenses have been revoked or who have surrendered their licenses as well as doctors who have been indefinitely suspended, must all reapply.

[150] As previously noted, however, the 2001 data remain missing so we simply do not know how many doctors who were disciplined in 2000 reapplied in 2001. Nonetheless, a reasonable assumption can be made from an examination of the other years that this number is relatively low.

[151] Specifically, the BME considered twenty-seven in 2000, seventeen in 2002, twenty-nine in 2003, seventeen in 2004, and twenty-two in 2005. Admittedly, the data are skewed by the fact that fewer years have elapsed in the case of recently sanctioned doctors—for these doctors reapplication is not yet a realistic possibility.

[152] Namely, sex-related, drug-related, and violent offenses, as well as offenses involving doctors behaving fraudulently and those involving insurance fraud.

[153] Interview #5, *supra* note 73. These doctors are possibly too pessimistic in many instances, considering that only eight applications resulted in denials of licensure in any form.

TABLE 5: REAPPLICATION RATES, 2000 AND 2002-2005

Disciplined in:	Reapplied in:	Unrestricted License	Limited License	Denial of License	Total
2000	2000	1	3	0	4
2000	2002	3	0	1	4
2000	2003	2	1	1	4
2000	2004	1	1	0	2
2000	2005	0	0	0	0
	Total	**7**	**5**	**2**	**14**
Disciplined in:	**Reapplied in:**	**Unrestricted License**	**Limited License**	**Denial of License**	**Total**
2002	2002	1	3	0	4
2002	2003	4	5	0	9
2002	2004	3	1	0	4
2002	2005	3	0	0	3
	Total	**11**	**9**	**0**	**20**
Disciplined in:	**Reapplied in:**	**Unrestricted License**	**Limited License**	**Denial of License**	**Total**
2003	2003	0	0	0	0
2003	2004	0	0	0	0
2003	2005	1	0	0	1
	Total	**1**	**0**	**0**	**1**
Disciplined in:	**Reapplied in:**	**Unrestricted License**	**Limited License**	**Denial of License**	**Total**
2004	2004	0	2	0	2
2004	2005	1	3	0	4
	Total	**1**	**5**	**0**	**6**
Disciplined in:	**Reapplied in:**	**Unrestricted License**	**Limited License**	**Denial of License**	**Total**
2005	2005	0	1	0	1
	Total	**0**	**1**	**0**	**1**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

their New Jersey license back. Third, doctors may have other healthcare-related employment (e.g. drug companies, research, or consulting) and may be content to remain in that arena. Fourth, some doctors who have committed egregious offenses may fear being shunned by the community even if they are able to get their license back. Finally, a revocation, even with the return of the

TABLE 6: STATUS AND RATES OF APPLICATION FOR REINSTATEMENT (REGARDLESS OF YEAR DISCIPLINED)

Nature of Offense	Unrestricted License	Limited License	Denial of License	Total
Professional	7	2	0	9
Psychological Disorder/Illness	0	1	0	1
CDS-related	0	1	0	1
Sex-related	7	5	3	15
Drug-related	19	21	1	41
Violent	0	0	0	0
Fraudulent Activities (non insurance)	7	3	2	12
Insurance Fraud	1	5	2	8
Unknown	22	4	0	26
Total	**63**	**42**	**8**	**113**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

license, places huge monetary obstacles in the way of restarting a practice with respect to obtaining malpractice insurance and eligibility for third party reimbursement from private insurance companies as well as from federally funded insurance companies.

When a doctor does attempt to regain his or her license, our respondents tell us that the readmission decision often has to do with something as prosaic as the memory span of the affected actors. For example, if the deputy attorney general that initially prosecuted the doctor/offender still holds the position and felt strongly about the case in the first instance, that doctor's application, all things being equal, is more likely to be denied. Another variable associated with readmission, as well as initial punishment, is (not surprisingly) the personal character of the doctor/offender. The BME has a profound appreciation for evidence of contrition in its offenders.[154] Thus, if a doctor admits guilt, does some sort of community service, anticipates possible punishments the BME will mete out, and shows remorse, the doctor will be treated much more kindly and generously by the BME. However, it is interesting to note that many of our

[154] This desire for contrition is not limited to the BME, but seems to be a common theme among medical boards in general. As an attorney defending doctors before the Arizona Medical Board points out,

> [O]ne important step to successful resolution of many disciplinary charges is often a cautious acknowledgement by the doctor that there is room for improvement . . . . The doctor's willingness to acknowledge room for improvement demonstrates that the doctor is reasonable and will cooperate, as long as the disciplining authority acts reasonably. When the doctor indicates a willingness to cooperate, the disciplinary authority is more likely to be willing to explore creative solutions.

Zeder, *supra* note 42, at 40.

respondents suggested that doctors are not naturally inclined to behave this way—the folk wisdom suggests that appearing contrite is not an easy posture for many physicians, a condition we heard referred to as "M.D.eity Syndrome."

B. *"Missing" Modes of Disposition:*

While our quantitative data are rich, we learned from our qualitative data that some disposition modes are not included in the quantitative data. There are some cases, for instance, which are settled outside of the formal BME procedures. For example, if a physician has problems with an insurance company, his attorney tries to keep the matter from reaching the BME by settling it directly with the insurance company.[155] Although the companies are required to report errant physicians, it should come as no surprise that this is not always the case.[156] There are also cases in which no action was taken or a private settlement was reached. In these cases, the public is kept in the dark about doctors who have offended but whose case was dropped by the DAG.[157]

Learning about these private settlements was akin to finding a "smoking gun." While one respondent told us that these are not as consequential as we had concluded and that they were used mostly to resolve unsubstantiated charges, another respondent disagreed and we tend to agree with the latter respondent. Specifically, we were informed that in relatively minor matters—probably more often than not matters in which there is *some* culpability—a bargaining strategy for defense attorneys is to get the relevant DAG to agree to a private settlement. These are not on the public record and, even compared to the mildest public sanction (reprimand), have no effect on the licensee in terms of obtaining insurance.

C. *Plea Bargaining*

Most criminal cases involving doctors, our interview respondents informed us, are settled by plea bargaining, with the majority of doctors receiving Pre-Trial Intervention. It is important to note that in negotiating these cases, de-

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[155] Interview #5, *supra* note 73.

[156] *Id.*

[157] In New York, the confidentiality of proceedings goes much further. In *Doe v. Office of Professional Medical Conduct of the New York. State Department of Health,*, 619 N.E.2d 393 (N.Y. 1993), the Court of Appeals of New York held that disciplinary proceedings against physicians must be confidential. Furthermore, in *Anonymous v. Bureau of Professional Medical Conduct of the New York State Department of Health*, 814 N.E.2d 440 (N.Y. 2004), the Court of Appeals of New York ruled that this confidentiality also includes those cases decided in the physician's favor. In New Jersey, on the other hand, once hearings reach the BME stage they are part of the BME meeting minutes and therefore publicly available. *See* State Board of Medical Examiners, Statutes and Regulations, su*pra* note 70, at 48.

fense attorneys often use licensure as a bargaining tool.[158] The defense attorney tries to persuade the prosecutor to consider a lesser criminal sentence if it can be shown that the doctor is in danger of losing his or her license or that there are other negative consequences that stem from criminal action short of losing a license (e.g. the various secondary effects of medical board sanctions). The defense attorney may also argue that without the license the doctor will not be able to make restitution.

The packaging of the criminal disposition and the BME disciplinary action were called "global resolutions" by some of our respondents. These are ways for the defense attorney to deal with both the civil (or criminal) and disciplinary authorities simultaneously. Global resolutions are attempts to allow the doctor-defendant to know where he or she stands in both the civil or criminal action and the disciplinary proceeding and to use outcomes in one setting as leverage in the others.

D. *Reciprocity*

Reciprocity of sanctions is used extensively for doctors in New Jersey, as shown in Table 3. Hearings in "sister state" actions are not held and often the disciplinary decision mirrors that of the other state's medical board. As Table 7 demonstrates, this is true in seventy-one percent of the reciprocal cases. We were told by respondents that, unlike New Jersey, other states are not as likely to accept sister state dispositions. Different states accord different weights to offenses; for example, insurance fraud in New Jersey is afforded the most weight, which may not be the case in other states.[159]

TABLE 7: NEW JERSEY BME SANCTIONS VIS-À-VIS SISTER STATES

Sanction	Equal	Unknown	Greater	Lesser	Total
Revocation	30	2	4	0	36
Surrender	13	0	2	1	16
Indefinite Suspension	36	3	5	2	46
Suspension (more than one year)	2	0	3	0	5
Suspension (one year or less)	9	2	2	2	15
Probation (more than one year)	17	3	1	0	21
Probation (one year or less)	1	1	2	2	6
Reprimand	11	9	0	2	22
Restrictions/Conditions	3	0	0	1	4
Total	122 (71%)	20 (12%)	19 (11%)	10 (6%)	**171**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

[158] Interview #6, *supra* note 74.

[159] Also, one of our respondents suggested an interesting inverse relationship between the number of licensed doctors and medical board severity. This of course is a matter requiring more intensive quantitative analysis and is ripe for future study.

This discussion returns us to the complicated story of how different "pictures" of the quantitative data shape a perception of a kind of leniency in physician punishments. First, if participants look at only felony offenses, including reciprocal actions (Table 2), we see that only forty-seven percent of the worst offenses result in the toughest sanctions—revocation or surrender—thus supporting the idea of leniency. Likewise, when we look at felony offenses, excluding reciprocal actions (Table 4), only fifty-seven percent of cases resulted in revocation or surrender. Thus, while New Jersey may be harsher than other states, less than half of the doctors disciplined in this state for felony offenses lose their licenses "permanently." (Table 2).

When reciprocal actions of any kind are *not* included in the data (see Table 3, not limited to felony offenses), the BME most often utilizes reprimands to sanction doctors, taking this approach in twenty-five percent of instances. Indeed, again excluding reciprocal actions, less than half resulted in suspensions of over one year (forty-eight percent), meaning that fifty-two percent of these cases resulted in the most lenient punishments. (Table 3). Looking at the data this way also comports with the perceived lack of severity on the part of the BME, as mentioned by several respondents.[160]

To summarize, a mixed conclusion about BME severity emerges from our qualitative and quantitative data. We begin with a consensus among our respondents that the BME is lenient in disciplining doctors—a frequent refrain of both the prosecutorial and defense sides. When we examined the quantitative data, however, it became clear that these data could be viewed in several different ways. First we looked at all data including reciprocal actions; then we considered the data absent reciprocal actions; and finally, we examined only felonies excluding reciprocal actions. The picture that emerged was one showing a marked pattern of leniency when all infractions, including reciprocal actions, are included. As demonstrated by Table 8, when we combine all offenses for all years, only thirty-six percent of disciplined doctors lose their licenses due to revocation or surrender. Significantly, the exclusion of reciprocal actions makes New Jersey look more severe in its punishment of doctors. However, as already demonstrated, nothing is permanent in New Jersey; that is, the loss of a license does not preclude a doctor from practicing again. Unlike the case of attorneys in the state, there is no permanence on the spectrum of sanctions for doctors.

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[160] This is, however, dependent on which data are being examined. When only *felonies* excluding reciprocal actions are considered, as they are in Table 4, sixty-seven percent result in the four most serious sanctions. Note, however, that even this means that thirty-three percent of doctors who commit felonies receive comparatively lenient sanctions. The overriding factor is that one hundred percent of doctors who commit felonies are not automatically and/or permanently barred from practice.

TABLE 8: TOTAL NUMBER OF SANCTIONS PER YEAR

Sanction	2000	2002	2003	2004	2005	Total
Revocation	23	29	13	15	5	85 (21%)
Surrender	11	14	17	12	5	59 (15%)
Indefinite Suspension	7	19	8	7	11	52 (13%)
Suspension (more than one year)	5	4	3	1	5	18 (5%)
Suspension (one year or less)	11	9	6	10	6	42 (11%)
Probation (more than one year)	4	5	7	6	9	31 (8%)
Probation (one year or less)	1	5	1	1	4	12 (3%)
Reprimand	19	15	20	14	13	81 (20%)
Restrictions/Conditions	1	2	4	7	3	17 (4%)
Total	**82**	**102**	**79**	**73**	**61**	**397**

Source: New Jersey State Board of Medical Examiners Public Disciplinary Notices, 2000 and 2002-2005

We have argued that four factors cumulatively contribute to this widespread perception we encountered that overall sanctions are not severe. First is the ability of doctors to get licenses back—as far as we can see, most doctors who reapply will be reinstated. Second is the "smoking gun" finding that some/many disciplinary actions are not reflected in the data—i.e. dispositions without formal sanctions. Third, plea bargaining may allow for some kind of global resolution in which the criminal punishment and the consequences on licensure are allowed to mitigate each other, thus furthering the notion of leniency. Finally, reciprocal actions make the overall sanctioning rate appear more lenient than it is for "New Jersey-only" violations.

E. *Final Diagnoses*

1. White Coats vs. White Shoes

As so little is known about the disciplinary process for various professions, it is important here that we offer some perspective as well as comparative observations drawn from our previous study of the process(es) of punishment for attorney felony offenders.[161] First and foremost, we note that doctors *as a class* are much more lenient when disciplining their own than are attorneys, especially given the permanent nature of disbarment. Respondents explained the BME's generally lenient treatment of doctors by noting that doctors are sympathetic to other doctors because of shared experiences—most notably the cost, duration, and perceived difficulty of medical school and residency. Moreover, many doctors feel that although their colleagues may inadvertently commit a minor offense, such as faulty record-keeping, only a fraction of these violations surface. This reinforces the notion that any member of the profession could stumble at some point and thus the disposition should tend toward leniency. As

[161] *See* Pinaire et al., *supra* note 12.

a function of—and perhaps contribution to—this sentiment, we should stress that our research indicates that there is as of yet no "fatal" offense that might be committed by doctors that is comparable to the knowing misappropriation of client funds which necessarily leads attorneys to be disbarred.[162] However, we are told that insurance fraud is increasingly assuming this position.[163]

2. The Privileges of "Privileges"

Virtually all respondents were keenly aware of the fact that a license to practice medicine is a privilege, not a right. Having said that, there was also a sense that there are some privileges that tend to come with this state-accorded status. Specifically, it appears to be easier for doctors to get their licenses back than it is for felons more generally to get their right to vote reinstated. In fact, doctors in New Jersey can get their licenses to practice back by virtue of the lack of permanence associated with all BME disciplinary sanctions, while numerous states categorically ban all convicted felons from voting (a practice that many would actually think of as a "right"),[164] or at least present enormous, sometimes insurmountable, difficulties in regaining access to this mode of political participation.[165] This arguably does not make sense; one might maintain, for example, that it is reasonable to believe that rights should be *more* easily regained than privileges.

Another way in which doctors may fare better in the criminal justice system than do "regular" offenders is in their experience vis á vis probation. Probation officers, we were told, value doctor-clients very highly, mostly because they are not used to this kind of responsible clientele, and indeed it is not uncommon for doctors to give officers medical advice and gifts.[166] Consequently, although we did not collect systematic data on this occurrence, we learned from our interviews that probation officers will often ask to end the probation early since they feel that the doctor has been rehabilitated.

3. Public Health

Alhough concededly speculative, there is yet another significant anomaly that surfaced in examining punishment of physicians. Much has been written about the irony of prison vocational training and the seeming impossibility of inmates getting jobs in these specialties once released.[167] In the case of doctors, however, it appears that criminal infractions, while taking a toll, frequently do not prevent the doctor from a return to practice once punishment is

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[162] *Id.* at 318.

[163] Interview #4, *supra* note 78.

[164] *See* Pinaire et al., *supra* note 8.

[165] *See* EWALD, *supra* note 8.

[166] Interview #5, *supra* note 73.

[167] *See, e.g.*, PETERSILIA, *supra* note 5, at 114-15.

over.[168] Moreover, some interview respondents informed us that the state sees itself as having an interest in rehabilitating doctors because it contributes so much money to the training of physicians. Conversely, this rehabilitative goal has not typically animated the treatment of "regular" offenders where retribution, deterrence, or perhaps simple incapacitation remain the primary goals of criminal justice officials.[169] Although unraveling the normative implications of this kind of differential treatment is beyond the scope of this article, it suffices here to note the contradictions.

VII. CONCLUSION

The discipline of doctors in a sense provides hope to those who believe in second chances. While collateral consequences do exist, they are generally not permanent, nor do they set impossible obstacles in the way of maintaining a livelihood. As suggested earlier, while any kind of penalty can hurt doctors, the data overall support the idea that doctors' professional lives do not end with the receipt of disciplinary sanctions.[170] Obviously, more research is needed. The idea of restricted licenses is a promising policy alternative, particularly practice with chaperones—a notion we previously raised as a possible alternative in the disciplining of attorneys.[171] It is true that there are occasional civic groups that agree to supervise a defendant, but the kind of full-time, hands-on chaperone employed for doctors in their practice is rarely prescribed in regular criminal trials and is a policy alternative worthy of more consideration.

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[168] Interview #5, *supra* note 73. On the other hand, an individual who was not a doctor prior to incarceration will find it nearly, if not completely, impossible to become one after being incarcerated. As Petersilia notes, "Licensing regulations, which apply to occupations ranging from law and medicine to collecting garbage and cutting hair, frequently contain broad enough standards of competency and honesty to result in flat proscriptions against all offenders." *Id.* at 114.

[169] We may be witnessing the beginning of a change in the prioritization of these goals. Whereas in the last few decades rehabilitation was abandoned in favor of punishment, deterrence, and incapacitation, rehabilitation in the guise of the more politically palatable goal of re-entry is clearly making a comeback. Even President Bush discussed the importance of programs designed to ease the transition from prison into society, stating, "America is the land of second chance, and when the gates of the prison open, the path ahead should lead to a better life." George W. Bush, State of the Union Address (Jan. 20, 2004), *available at* http://www.let.rug.nl/usa//P/gwb43/speeches/state_union_2004.htm. *See also* Chris Suellentrop, *The Right Has a Jailhouse Conversion*, N.Y. TIMES MAG., Dec. 24, 2006, at 47; JUSTICE KENNEDY COMMISSION, *supra* note 7.

[170] Revocation is rarely permanent. Most doctors whose licenses are revoked do not reapply; however, as stated in the text, of those that reapply most get their licenses back. Those that do not reapply may be involved in another related profession or they may be licensed in another state. It is true, though, that some doctors may not reapply because they fear they will not get their license back.

[171] Pinaire et al., *supra* note 12.

Likewise, the Professional Assistance Program presents an important alternative to prison terms for people who have broken the law but are in need of counseling and rehabilitation rather than punishment. Instead of "locking them up" and continuing to overcrowd prisons with men and women convicted of drug crimes, a system of care akin to the PAP that addresses the source of the problem has a great deal of potential. We are not advocating a ceasefire in the "War on Drugs," but merely an alternative that is more likely to produce positive results.[172]

Future research will be systematic and comparative, extending across jurisdictions and professions. Trends over time should also be studied, such as the number of doctors with revoked license who eventually get them back. Thus, it is clearly important to build upon our comparison between attorneys and doctors in New Jersey to study the treatment of professionals and other licensees within and across states. In addition, surveys of doctors who do not reapply would be helpful, as would tracking of reinstatements over a longer period of time. Furthermore, more interviews with actual defendants in these cases, as well as studies which link court records and Board discipline, should be undertaken.

Finally, we look back at the study and underline two themes. The first is a methodological one—a surfacing of ways of understanding a complicated reality by triangulating quantitative, qualitative, and interpretive data. It would be neater, cleaner, and clearer were we to rely on one of these data sources; unfortunately, reality precluded this kind of straightforward analysis and the generation of easily digestible findings. As we discuss throughout the article, we are attempting to understand why a perception (and maybe reality) of leniency in physician sanctioning exists despite some quantitative data suggesting otherwise. To do so we need to simultaneously consider all quantitative data (all offenses and reciprocal actions) as well as probe the interview data for dispositions not explicitly acknowledged in the quantitative data. If nothing else, an important lesson is learned: trekking through multiple sources of data is required to appreciate the murky reality which constitutes physician sanctioning.

The second theme is ultimately a normative one and is again implied by the data. This normative matter has several pieces, all of which revolve around the question of what "price" is "right" for doctors who commit felonies. Should sanctions be animated by a sense that the violation of trust by the doctor trumps any other considerations and thus ought to militate for a long or permanent loss

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[172] Indeed, the recent popularity of "drug courts" is a reflection of this move towards some rehabilitative alternative to imprisonment. *See generally* Eric Jensen and Clayton Mosher, *Adult Drug Courts: Emergence, Growth, Outcome Evaluations, and the Need for a Continuum of Care*, 42 IDAHO L. REV. 443 (2006); Frederick Massie, *Rhode Island Adult Drug Court Offers Alternative Sentencing and Hope*, 53 RHODE ISLAND BAR J. 17 (Nov/Dec. 2004); William Simon, *Criminal Defenders and Community Justice: The Drug Court Example*, 40 AM. CRIM. L. REV. 1595 (2003).

of license? Or, on the other hand, are concerns about the "waste" of medical training made all the more compelling in light of the need for physicians in many underserved areas of our state? Our earlier focus groups suggest little public support for having doctors convicted of felonies "serving their sentence" in areas in need of physicians;[173] still, this policy consideration should remain on our agenda. Also in the normative area are matters of physician sanctioning versus the sanctioning of other professionals—for example, attorneys. Does it make sense, for instance, that for certain offenses disbarment of attorneys is mandatory and permanent? Should this be a model for doctors, or, conversely, should the second-chance tradition, seemingly afforded to a greater extent in the medical profession, be imported to the sanctioning of attorneys?

Finally, there are normative matters of the consequences of felony convictions for physicians versus felony convictions for the general populace. The reentry literature is filled with horror stories of how felony convictions preclude numerous defendants from many, even rather prosaic, jobs—sometimes forever.[174] Yet, physicians appear to have the very kind of second chance in their prestigious profession that is not possible for many other offenders in less prestigious fields. This certainly does not mean that a more punitive attitude is the "right" resolution. Instead, we think it worthwhile to consider the "medical model" more generally. Most importantly, we think that the reconsideration of these normative questions surfaces as a concern significantly implicated in the findings of the present study.

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[173] *See* Heumann et al., *supra* note 11, at 36 (reporting that focus groups were asked if it was prudent to have doctors practice in underserved areas rather than lose their licenses, and the respondents felt this was not an appropriate resolution, bridling at the thought that underserved areas should have services provided by doctors guilty of criminal offenses).

[174] *See generally* Harry Holzer, Steven Raphael & Michael Stoll, *Will Employers Hire Former Offenders?: Employer Preferences, Background Checks, and Their Determinants*, *in* IMPRISONING AMERICA: THE SOCIAL EFFECTS OF MASS INCARCERATION 205 (Mary Pattillo, David Weiman & Bruce Western eds., 2004); Debbie Mukamal & Paul Samuels, *Statutory Limitations on Civil Rights of People with Criminal Records*, 30 FORDHAM URB. L.J. 1501 (2003); PETERSILIA, *supra* note 5; TRAVIS, *supra* note 4.

APPENDIX

Coding was a difficult, time-consuming process involving more approximation than science. In order to understand our categories it is thus necessary to explain how we coded offenses and sanctions.

A) Offenses: We divided offenses into nine categories (in order from least to most serious): unknown, professional, psychological disorder/illness, CDS-related, sex-related, drug-related, violent, fraudulent behavior, and insurance fraud. As many doctors committed multiple offenses cutting across categories, we assigned to the doctor only the offense deemed most serious.[175]

1) Unknown: Unknown offenses are those where it is not stated what offense the doctor committed.

2) Professional: While all offenses adversely affect the medical profession and are violations of the profession's code of ethics, we considered only those offenses directly related to the practice of medicine as professional offenses. Thus, this category includes those instances where doctors were disciplined for negligence, record-keeping violations, patient complaints, deviations from the accepted standard of care, and related violations which, while felonies may fall into this category, are generally not felony offenses.

3) Psychological disorder/illness: These offenses are those related to the psychological state of the doctor—essentially, doctors fell into this category if they were found unable to practice due to their mental state.

4) CDS-related: We decided to separate CDS-related offenses from professional offenses because they are more serious than those offenses included under the professional category and are more likely to be felonies. This category includes those offenses where the doctor indiscriminately, excessively, or improperly prescribed CDS.

5) Sex-related: This category includes all offenses related to sex, from consensual sex with a patient to viewing child pornography to violating peeping tom statutes.

6) Drug-related: As already shown, we created a separate category for those offenses specifically relating to prescribing of CDS. This category, on the other hand, includes those offenses where the doctor him/herself used drugs or alcohol, received a DUI, or was found in possession of or selling drugs.

7) Violent: The offenses in this category are those where the doctor committed, or attempted to commit, an act of physical violence, including harassment and intimidation, attempted murder or murder, and assault.

8) Fraudulent behavior: This category encompasses any kind of fraud, misrepresentation, and theft excluding insurance fraud.

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[175] The decision regarding which offenses should be considered most serious was a difficult one to make and is based on interview data, actual Board actions, and considerations of what being a doctor entails.

9) Insurance Fraud: This category is self-explanatory; however, we should mention that we decided to separate this category from the fraudulent behavior category due to the special nature of the relationship shared by doctors and insurance carriers.

B) Sanctions: We divided sanctions into nine categories (in order from least to most serious): restrictions/conditions, reprimand, probation of one year or less, probation of over one year, suspension of one year or less, suspension of over one year, indefinite suspension, surrender, and revocation. As we mention in the text, we applied a "truth in sentencing" model in determining which sanction to apply in each case. In addition, as with the coding of offenses, since many disciplinary decisions involve multiple sanctions we only applied the sanction deemed most serious.