# DOING TIME FOR CLINICAL CRIME: THE PROSECUTION OF INCOMPETENT PHYSICIANS AS AN ADDITIONAL MECHANISM TO ASSURE QUALITY HEALTH CARE

> In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing . . . . If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.[1]

## I. INTRODUCTION

Over the past several years, there has been an increase in the number of prosecutions of health care professionals[2] charged with the death of patients. While these cases may not signal a long-term trend,[3] recent developments raise concern for the medical community.[4] At the forefront of this concern is the point at which an error[5]

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[1] Daniel M. Ginter, *Nursing The Problem: Responding to Patient Abuse in New York State*, 28 COLUM. J.L. & SOC. PROBS. 559, 559 (1995) (quoting the Hippocratic Oath, which all physicians must take prior to being admitted to the profession of medicine).

[2] In the context of this Note, the term "health care professional" refers to physicians unless otherwise noted. Physician means, for the purpose of this article, "a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by a State." 45 C.F.R. § 60.3 (1996). There are, however, cases in which other health care professionals, such as nurses and dentists, have also been prosecuted for the death of patient. *See, e.g.*, People v. Spence, 648 N.Y.S.2d 636, 637-38 (App. Div. 1996) (upholding the conviction of a nurse for willfully violating public health laws when the nurse failed to administer medication to patients in a nursing home); *Police Seek Charges in Fatal Mistake*, ORLANDO SENTINEL, Dec. 16, 1994, at C6, *available in* 1994 WL 4937663 [hereinafter *Police Seek*] (discussing the possibility of prosecuting a nurse for manslaughter following the nurse's accidental killing of a patient by administering a mistaken injection); Debbie Salamone, *Dentist Sorry for Death, Fights to Keep License*, ORLANDO SENTINEL, Dec. 5, 1991, at B3, *available in* 1991 WL 9079120 (reporting the conviction of a dentist for manslaughter when an eight-year-old girl died after the dentist administered the wrong dosage of medication to the youth).

[3] *See* Francis P. Bensel & Barbara DeCrow Goldberg, *Prosecution and Punitives For Malpractice Rise, Slowly*, NAT'L L.J., Jan. 22, 1996, at B7, B10 (concluding that the prosecution of health care providers is an exception to the rule rather than a trend).

[4] *See* Alexander McCall Smith, *Criminal or Merely Human?: The Prosecution of Negligent Doctors*, 12 J. CONTEMP. HEALTH L. & POL'Y 131, 131 (1995) (noting that the marked increase in the number of prosecutions against physicians for the death of

in professional judgment warrants criminal liability, as opposed, or in addition, to more traditional civil sanctions.[6]

The medical profession is unique in that, unlike other professions, physicians essentially have an affirmative duty to take risks.[7] Physicians are required to make crucial judgments and perform their duties with a high degree of skill.[8] At the same time, physicians are human and inevitably make mistakes.[9] While a mistake by a physi-

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patients has led to heightened concern among the medical community); *see also Doctors Concerned By Criminal Charges*, ST. PETERSBURG TIMES, Apr. 2, 1991, at 4B, *available in* 1991 WL 9132166 (noting that doctors in Florida are increasingly alarmed by the trend to charge doctors criminally for medical mistakes); Diane M. Gianelli, *MD Charged With Manslaughter After Nursing Home Patient Dies*, AM. MED. NEWS, Apr. 22-29, 1991, at 1, 2 (explaining that a state medical association raised money for a doctor's defense because it feared that the case could have severe repercussions); Thomas Maier, *More Doctors Face Prosecution; Crimes Charged in Cases of Deadly Error*, NEWSDAY, Apr. 18, 1995, at A35, *available in* 1995 WL 5107204 (reporting on the increased number of letters from concerned doctors to medical groups, including the American Medical Association (AMA), concerning the prosecution of physicians); *Malpractice or Homicide?*, WASH. POST, Apr. 18, 1995, at A16, *available in* 1995 WL 2089365 (explaining that the medical community is concerned with the new approach toward prosecuting health care professionals for medical errors that result in death).

[5] The term error refers to a "'performance which deviates from the ideal.'" Smith, *supra* note 4, at 135 (citation omitted). All errors, however, are not created equally. *See id.* at 136. There exists a distinction between a mere slip, which is a common occurrence in everyday life that is often due to a "malfunction of routine methods of dealing with familiar stimuli, and 'mistakes,' which involve faulty decision-making." *Id.*; *see also* JOHN KAPLAN & ROBERT WEISBERG, CRIMINAL LAW CASES AND MATERIALS 193-95 (2d ed. 1991) (citing James Reason, *The Psychopathology of Everyday Slips*, THE SCIENCES 45, 49 (Sept./Oct. 1984) (opining that the only difference between mental errors that lead to horrific accidents and the slips of everyday life is environmental, as opposed to psychological)). Medical errors often are the result of inadequate technical or interpersonal care, incompetence, or inattentiveness. *See* Timothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 531 (1988).

[6] *See* Jost, *supra* note 5, at 525. Traditional civil sanctions include medical malpractice suits and disciplinary actions by peer review groups and state licensing boards. *See id.*

[7] *See* Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 689 (1991) (describing the medical profession as a "high-risk occupation"). The Hippocratic Oath states that the duty of a physician is "'[to] follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.'" JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 4 (1984) (citation omitted). To the extent that medicine is not a perfect science, physicians are required to take risks everyday, provided the patient is informed of the risks and benefits of the proposed medical procedure, and the patient consents. *See id.* 48-84 (discussing the development of informed consent).

[8] *See* Smith, *supra* note 4, at 135.

[9] *See* Jost, *supra* note 5, at 531 (noting that the provision of medical care is extremely complex and the best health care professionals sometimes commit errors

cian may be grounds for malpractice or disciplinary action, it does not necessarily follow that the physician committed a crime.[10] In some instances, however, it may be appropriate, perhaps even desirable, to impose criminal sanctions against a physician as a mechanism to regulate incompetent[11] physicians and to assure quality health care[12] for consumers.[13]

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with devastating results); Catherine S. Meschievitz, *Efficacious or Precarious? Comments on the Processing and Resolution of Medical Malpractice Claims in the United States*, 3 ANNALS HEALTH L. 123, 126 (1994) (acknowledging that an inherent part of the delivery of medical care is medical error); *see also* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 767 (1997) (explaining that, "[u]nfortunately, medicine is as much art as science"). Several studies have documented the rate of medical errors in health care institutions. For example, one study concentrating on hospitalization in New York State revealed that there was a four percent risk to patients of suffering an "adverse event," defined in the study as an event that lengthened a hospital stay by one or more days or resulted in death. *See* Meschievitz, *supra*, at 127 (citing HARVARD MEDICAL PRACTICE STUDY GROUP, PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION AND PATIENT COMPENSATION IN NEW YORK (1990)). Additionally, an "observation study" of a hospital in Chicago revealed that (1) 44% of the hospital's patients experienced one error while hospitalized, (2) almost 20% experienced multiple errors, and (3) 14% of the cases resulted in a serious injury, defined as death or permanent disability. *See id.* at 127-28 (citing Lori B. Andrews, Medical Error and Patient Claiming in a Hospital Setting, Paper prepared for the Law & Society Association Annual Meeting, in Chicago, Ill. (May 30, 1993) (on file with the ANNALS OF HEALTH LAW)); *see also* Robert W. Dubois & Robert H. Brook, *Preventable Deaths: Who, How Often, and Why?*, *in* ANNALS INTERNAL MED. 582, 586, 588 (1988) (finding that 14% to 27% of the deaths that occurred in the hospitals studied may have been preventable; however, the study was limited to patients with pneumonia, myocardial infarction, or cerebrovascular accident).

[10] *See* JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW 113 (2d ed. 1995) (explaining that, although negligent conduct constitutes a breach of duty of care, every breach is not necessarily a crime); *see also* Hall v. Hilbun, 466 So. 2d 856, 866 (Miss. 1985) (explaining that "[a] competent physician is not liable *per se* for a mere error of judgment, mistaken diagnosis, or the occurrence of an undesirable result"). For example, a state prosecutor did not file manslaughter charges against a hospital, surgeon, or nurse anesthesiologist in the death of a four-year-old patient who died from cardiac arrest during an operation to suture wounds from a dog bite. *See Pa. Prosecutor Finds No Grounds for Charges Against Surgeon*, AM. MED. NEWS, June 1, 1990, at 5, *available in* 1990 WL 3259745. An autopsy revealed that the child's heart muscle had an inflammation that, if present before the accident, could have resulted in the cardiac arrhythmia during anesthesia. *See id.* The prosecutor explained that a mere deviation from the accepted standard of medical care does not constitute criminal negligence. *See id.*

[11] The term "incompetent," as used in this Note, refers only to the provision of medical care that falls below the acceptable standard of care determined by the medical profession. It does not encompass unprofessional conduct such as the abuse of drugs or alcohol, sexual misconduct, insurance fraud, or the illegal prescription of controlled substances. Nor does this Note address situations in which a patient's death is caused by an individual practicing medicine who does not possess an appropriate medical license.

[12] The Institute of Medicine defines quality of health care "as the degree to

The pursuit of quality health care by the medical profession and health care institutions is not a new phenomenon.[14] Recently, however, with the systematic shift away from fee-for-service care to managed care,[15] the concern among consumers[16] and the federal gov-

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which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." INSTITUTE OF MEDICINE, ASSESSING HEALTH CARE REFORM 34 (Marilyn J. Field et al. eds., 1993); *see also* AVEDIS DONABEDIAN, THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT 4-6 (1980) (noting the complexity in arriving at a single definition for the term quality, but ultimately defining quality health care to mean "that kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts."); Jost, *supra* note 5, at 530 (stating that "[a] physician of high quality is one who consistently delivers technical care that maximizes benefits over risks and who relates appropriately to his patients").

[13] Assuring quality health care, or quality assurance, means, for purposes of this Note, the process used "to monitor the quality of care provided to patients and ordinarily includes measures of available resources and the process of care, as well as patient outcomes." Wendy K. Mariner, *Outcomes Assessment in Health Care Reform: Promise and Limitations*, 20 AM. J.L. & MED. 37, 38 (1994).

[14] *See* Jost, *supra* note 5, at 525 (emphasizing that the law has been concerned with the quality of heath care since ancient times). For example, the Code of Hammurabi, a set of laws prepared by Babylonian Kings dating back to 1792 B.C., mandated that a doctor's hand be cut off when the doctor's negligence resulted in the death of a patient or ruined a patient's sight. *See id.*; BLACK'S LAW DICTIONARY 715 (6th ed. 1990). State licensing boards, which monitor physicians' competence, *see infra* Part II.C., have existed in the United States since the 1600s. *See* Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 827 (1995). In the 1970s, consumer groups began to demand that the issue of competence be addressed, and the notion of peer review, initiated by the federal government but later adopted by health care institutions and state licensing boards, emerged as a mechanism for quality assurance. *See id.* at 832-33.

[15] Managed care refers to a system of health insurance that controls both the payment and delivery of health care services. *See* Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-offs*, 32 HOUS. L. REV. 1319, 1321 n.1 (1996). Managed Care Organizations (MCOs) regulate the cost, volume, and type of health care services through contracting with health care providers and controlling the provision of health care through organization controls and financial incentives. *See id.* Traditionally, under fee-for-service or insurance indemnity plans, the insured would contract with the insurance company, choose a physician, pay the physician when services were rendered, and be reimbursed by the insurance company. *See id.* Managed care dramatically altered this relationship because under a managed care system, the insurer provides the medical services directly, or contracts with health care providers, such that the insured no longer has total control over choosing a physician. *See id.*

Many different forms of managed care exist—the most familiar are health maintenance organizations (HMOs) and preferred provider organizations (PPOs). *See* Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399, 401 (1996). HMOs provide extensive medical services to subscribers through a predetermined panel of physicians. *See* Rodwin, *supra*, at 1321 n.1. Subscribers pay a portion of their medical services in the form of set monthly

ernment to monitor and assure quality health care has reached a new level of urgency.[17] The alarm over quality of care is not unfounded as indicated by a growing body of evidence suggesting that incompetent physicians pose a serious threat to consumers' health.[18]

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premiums and nominal fees, such as copayments. *See id.* From this pool of resources, the HMO pays for the insured's services; therefore, the HMO has a vested interest in the provision of cost effective health care. *See id.* In a PPO, however, an insurer contracts with a limited number of physicians who provide medical care at discounted fee-for-service rates. *See* Latham, *supra*, at 401. An insured may choose to use a physician that is not a preferred provider; however, the insured usually must pay stiff penalties, such as high deductibles or copayments. *See id.*

Essentially, managed care systems, regardless of the form, have the same underlying goal: "[C]ontrolling a provider's behavior through financial incentives." Rodwin, *supra*, at 1321 n.1. The key element of any managed care plan is the mechanism used by the organization to control costs. *See* Latham, *supra*, at 401. For example, some mechanisms to control costs are

> initial screening of patients by a gatekeeper nurse or physicians whose approval is required prior to ordering expensive services and referrals to specialists; second opinion requirements prior to referrals for specialty care or hospitalization; organized contemporaneous case review or retrospective utilization review (UR) to spot inappropriate care; programs to educate providers as to medical costs; a concentration on provision to enrollees of preventive care (such as inoculation) designed to limit their need for costly services in the future; use of medical care protocols to standardize and control treatment; and use of financial incentives (copayments and deductibles) to reduce insureds' utilization of services.

*Id.* (citation omitted).

[16] Consumers, in this Note, refers not only to patients but also to those individuals who are well and not under the supervision of a physician. *See* Rodwin, *supra* note 15, at 1323 n.7 (cautioning that because the physician and patient share a fiduciary relationship, it "is more complex than an ordinary consumer-producer relationship"). *But see* Jacobi, *supra* note 9, at 708-30 (positing that the fiduciary role of the physician in the patient-doctor relationship has eroded due to the advent of managed care).

[17] Critics of the medical profession's self-policing system attribute the trend in prosecuting physicians for incompetent care to the system's failure to discipline physicians adequately. *See* Maier, *supra* note 4, at A35. For example, the Director of the Washington Public Citizens' Health Research Group stated: "Everyone is becoming aware that the doctor-run disciplinary system isn't working as well as it should, and something else should be done." *Id.*; *see also* Bensel & Goldberg, *supra* note 3, at B7 (noting that some commentators suggest that the rise in prosecution of health care providers is attributable to the lack of adequate supervision by state licensing boards); Jost, *supra* note 5, at 526 & n.5 (observing a "rash of federal legislation" aimed at assuring quality medical care, such as the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101, 11111-11152 (1994) (HCQIA)); Linda Oberman, *Defining Clinical Crime; New Cases Raise Questions On What Goes to Court*, AM. MED. NEWS, Sept. 6, 1993, at 2, *available in* 1993 WL 12219071 (noting the dismay of the director of New York City's Center for Medical Consumers at the inadequacy of current quality assurance mechanisms such as state licensing programs); *infra* notes 100-35 and accompanying text (discussing HCQIA).

[18] *See* Adler, *supra* note 7, at 690 & n.26 (citing research findings that anywhere

One justification for the prosecution of physicians for negligent conduct is that physicians will exercise greater care if they know that their negligence might lead to criminal charges.[19] If, however, mechanisms of private regulation such as medical malpractice suits and disciplinary actions are not adequately monitoring physicians' competence, resorting to the criminal law to punish physicians, as opposed to addressing the inadequacies of private regulation, may be unjust.[20] This is particularly true when the physician did not act with a "careless or cavalier attitude" towards the patient.[21] Furthermore, many health care professionals argue that prosecuting physicians for negligent medical errors will exacerbate the practice of defensive medicine[22] and thereby increase the cost of health care.[23]

Apart from what the medical profession believes is the most appropriate way to handle incompetent physicians, there remains concern over what mechanism best protects consumers. As the relationship between patient and physician, a situation once marked by trust and confidence, becomes more tenuous, patients will lose confidence in the medical profession's system of self-policing for quality assurance.[24] Moreover, because the average consumer lacks the req-

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from 4% to 30% of doctors are incompetent); Jost, *supra* note 5, at 538 n.77 (citing a study that estimates 4% to 30% of physicians are incompetent); Buddy Rake & Bobby Thrasher, *Medical Malpractice Myths, Truths and Solutions*, 32 ARIZ. ATT'Y 20, 24 (1996) (noting that "findings increasingly suggest that much iatrogenic injury is being committed by incompetent physicians"); Robert Steinbrook & Virginia Ellis, *Medical Board Lagging in Disciplinary Action Doctors: A Judge's Rebuke of State Agency's Role in* Klvana *Case Underscores Criticism From Other Sectors*, L.A. TIMES, May 13, 1990, at 1, *available in* 1990 WL 2396104 (reporting that Harvard University researchers assessed that poor medical care caused permanent medical disability in 2500 cases in New York during 1984 and played some role in the deaths of over 13,000 patients); *see also supra* note 9 and accompanying text (discussing statistical evidence on the rate of medical errors).

[19] *See infra* notes 232-33 and accompanying text (discussing the utilitarian notion of punishment).

[20] *See* Smith, *supra* note 4, at 137 (opining that "the only state of mind which is deserving of punishment is that which demonstrates an intention to cause harm to others, or where there is a deliberate willingness to subject others to the risk of harm").

[21] *See id.* at 135.

[22] Defensive medicine refers to the practice of ordering unnecessary and excessive diagnostic tests to guard against potential lawsuits. *See* DAVID M. HARNEY, MEDICAL MALPRACTICE 417 (2d ed. 1987); *see also* Jost, *supra* note 5, at 574 (defining defensive medicine as treatment provided only to avoid malpractice liability where the expense is disproportionate to the possible injury it seeks to avoid).

[23] *See infra* note 245 (noting the economic effect of the practice of defensive medicine on the health care industry).

[24] *See* Jacobi, *supra* note 9, at 706-07 (arguing that managed care's structural changes in health care financing have weakened the physician-patient relationship to the extent that patients can no longer rely on their physician's loyalty as the pri-

uisite expertise and time to make educated judgments concerning the quality of medical services,[25] purchasers will look to other mechanisms, including criminal sanctions, to hold incompetent physicians more accountable for their actions.

This Note addresses the perceived inadequacies of the private regulation of physician competence and examines whether criminal sanctions offer an effective solution. Part II of this Note discusses the traditional approaches used to address incidents of medical error, including medical malpractice civil suits, state medical board licensing, and professional disciplinary actions by peer review committees. Next, Part III outlines the role of criminal law as an additional method of assuring quality health care by analyzing the degree of negligence required to prosecute a health care professional for a fatal clinical error and by examining several highly publicized cases.[26] In Part IV, this Note focuses on general theoretical arguments for and against criminal punishment for fatal clinical errors. In addition, Part IV addresses the practical effects of criminal sanctions on the medical profession and patient care. Part V concludes by arguing that if civil and criminal mechanisms of quality assurance operate in tandem, rather than simply coexisting, the gaps that currently exist in the quality assurance system may adequately be filled.

## II. TRADITIONAL MECHANISMS FOR MONITORING PHYSICIAN COMPETENCE

### A. *Introduction*

Despite the troubling evidence concerning the number of incompetent physicians in the United States,[27] the traditional mechanisms for monitoring physician incompetence and ensuring the quality of health care have proven largely inadequate.[28] Medical malpractice litigation focuses on individual medical errors that result

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mary mechanism of quality assurance).

[25] *See* Jost, *supra* note 5, at 560-64 (noting that because most consumers lack technical knowledge and medical expertise, health care is essentially a "'credence good,' meaning that the consumer must ultimately trust that [the care] was helpful, but can never know for sure") (citation omitted).

[26] This part also details several situations in which physicians have been criminally charged for medical errors that resulted in a patient's death. The term "case," in this section, is also used to denote reported trials and appeals as well as press reports covering criminal charges for which there is no reported decision.

[27] *See supra* note 18 (noting recent studies documenting statistical evidence on the percentage of incompetent physicians practicing in this country).

[28] *See infra* notes 53-63, 70-89, 95-99, 123-38 and accompanying text (discussing the inadequacy of the current mechanisms of quality assurance).

in injury, relies on a judge or jury to evaluate the alleged medical errors, and imposes monetary sanctions if the physician is found liable.[29] In addition, state medical licensing boards monitor the quality of health care by inspecting physician practices to ensure that the quality of care delivered meets the state's standards and impose sanctions, such as suspending or revoking physicians' licenses, when the care fails to meet that requisite standard.[30] Also, professional disciplinary systems rely on peer review organizations to monitor the quality of physicians' conduct at a specific institution.[31] By imposing coercive sanctions, including the denial, revocation, or suspension of staff or clinical privileges, peer review organizations influence physicians' behavior.[32] Unfortunately, however, controlling the quality of health care by monitoring physician competency leaves much to be desired.[33]

### *B. Medical Malpractice*

The two principal objectives of medical malpractice are to reimburse injured patients and to monitor the quality of health care.[34] Malpractice litigation is a legal approach, through the tort system, that seeks to deter health care professionals from practicing negligently and committing medical errors.[35] In general, tort law imposes obligations on individuals to conduct themselves in a manner that will not result in injury to others.[36] Unlike criminal law, which allows the state to penalize the wrongdoer to protect the common interests of society, tort law affords an injured party an opportunity to seek

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[29] *See* Adler, *supra* note 7, at 694-95; Jost, *supra* note 5, at 533.

[30] *See* Jost, *supra* note 5, at 533, 535.

[31] *See id.* at 553-54.

[32] *See id.* at 554-55. Physicians are typically not employees at the hospitals in which they practice, but rather are granted privileges to admit patients and use the hospitals' facilities as independent contractors. *See id.* at 553-54. The particular hospital's governing board, based on the recommendation of the incumbent medical staff, decides whether staff and clinical privileges should be granted. *See id.* at 554. Having been admitted to the medical staff, the physician can admit patients. *See id.* The type of procedures the physicians are permitted to perform in the hospital, however, is determined by the extent of their clinical privileges. *See id.* It is common for physicians to have staff privileges at more than one hospital. *See id.*

[33] *See infra* notes 53-63, 70-89, 95-99, 123-38 and accompanying text (discussing the inadequacy of the current mechanisms).

[34] *See* Adler, *supra* note 7, at 694-95; Jost, *supra* note 5, at 572 (explaining that medical malpractice is "[t]he primary legal, as opposed to social or economic, means of quality assurance").

[35] *See* Adler, *supra* note 7, at 694; Jost, *supra* note 5, at 572.

[36] *See* WILLIAM L. PROSSER ET AL., CASES AND MATERIALS ON TORTS 1 (8th ed. 1988).

individual compensation from the wrongdoer for losses suffered.[37] The potential for liability deters the repetition of harmful conduct.[38]

In a negligence case, comparing the wrongdoer's conduct with the conduct expected of a reasonable and prudent person in the same or similar circumstances determines liability.[39] Liability attaches only when the wrongdoer fails to exercise this reasonable standard of care.[40] Consequently, in the context of medical malpractice, a physician will be held liable when the physician's conduct falls below the standard level of care.[41] The standard of care to which a physician is held differs, however, because the reasonableness of the physician's conduct is not compared to that of a reasonable person; rather, it is compared to the special skill, training, and knowledge of physicians under the same or similar conditions.[42] Therefore, medi-

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[37] *See* DAN B. DOBBS ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 1, at 5-6 (W. Page Keeton ed., 5th ed. 1984) (discussing the function of tort law).

[38] *See id.* § 4, at 25-26 (explaining that although the deterrent effect of tort law is not controlling, it often influences the decision to impose liability on the wrongdoer).

[39] *See* Alan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 558 (1959); *see also* DOBBS ET AL., *supra* note 37, § 32, at 173 (noting that the entire theory of negligence presumes "some uniform standard of behavior").

[40] *See* RESTATEMENT (SECOND) OF TORTS § 298 (1965) (explaining that conduct is negligent only if performed without the care that a reasonable person in the same position, with the same competence and information, would exercise).

[41] *See* HARNEY, *supra* note 22, at 411.

[42] *See* DAVID W. LOUISELL & HAROLD WILLIAMS, MEDICAL MALPRACTICE ¶ 8.04, at 8-30 to 8-33 (1997); *see also* DOBBS ET AL., *supra* note 37, § 32, at 185-87 (noting that professionals, in addition to exercising reasonable care, must also possess the minimum standard of ability and special knowledge required by the particular profession). Most courts define the duty of care as the minimum amount of skill and knowledge possessed by a competent physician. *See, e.g.*, Hall v. Hilbun, 466 So. 2d 856, 873 (Miss. 1985). Some courts, however, interpret the duty of care to mean the care exercised by an average physician. *See, e.g.*, Boyce v. Brown, 77 P.2d 455, 457 (Ariz. 1938). *But see* Shilkret v. Annapolis Emergency Hosp. Ass'n., 349 A.2d 245, 252-53 (Md. Ct. Spec. App. 1975) (disapproving of the application of the average physician standard and emphasizing that the standard should be based on the skill and care of a reasonably competent physician); HARNEY, *supra* note 22, at 416 (opining that the appropriate standard of care should not refer to the average medical conduct but rather should refer to "*good* medical practice"). Comment (e) to section 299A of the Restatement Second of Torts explains the appropriate standard of care:

> In the absence of any such special representation, the standard of skill and knowledge required of the actor who practices a profession or trade is that which is commonly possessed by members of that profession or trade in good standing. It is not that of the most highly skilled, nor is it that of the average member of the profession or trade, since those who have less than median or average skill may still be competent and qualified. Half of the physicians of America do not automatically become negligent in practicing medicine at all, merely

cal malpractice litigation serves as a mechanism to assure that quality medical care is provided to patients by subjecting health care professionals whose conduct falls below acceptable standards of care to retrospective review.[43] In theory, if health care professionals are forced to pay for the cost of their medical errors, they will undertake preventive measures to assure that medical errors do not occur.[44] Furthermore, medical malpractice litigation also has the potential to punish physicians for recklessly or wantonly providing negligent medical care through the award of punitive damages.[45]

Liability for malpractice does not automatically attach when a physician renders medical treatment that produces a bad result.[46]

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because their skill is less than the professional average.

RESTATEMENT (SECOND) OF TORTS § 299A cmt. e.

[43] *See* Jost, *supra* note 5, at 572.

[44] *See id.*

[45] *See* Graham v. Columbia-Presbyterian Med. Ctr., 588 N.Y.S.2d 2, 3 (App. Div. 1992) (holding that if the conduct of the defendant was "'intentional, malicious, outrageous, or otherwise aggravated beyond mere negligence,'" punitive damages could be awarded) (citations omitted); Spinosa v. Weinstein, 571 N.Y.S.2d 747, 754 (App. Div. 1991) (concluding that only where the tortfeasor's alleged actions amount to "'gross recklessness or intentional, wanton or malicious conduct'" are punitive damages available) (citations omitted); *see also* Cerisse Anderson, *Punitive Award for Doctor's Reckless Treatment*, N.Y.L.J., Nov. 4, 1991, at 1 (noting that punitive damages against a physician were upheld by a trial court judge because the physician's "'actions in his course of treatment were committed in such a manner to be wanton and reckless and without regard to the rights and safety of his patient'") (citation omitted). Further, punitive damages include

> damages on an increased scale, awarded to the plaintiff over and above what will barely compensate him for his property loss, where the wrong done to him was aggravated by circumstances of violence, oppression, malice, fraud, or wanton and wicked conduct on the part of the defendant, and are intended to solace the plaintiff for mental anguish, laceration of his feelings, shame, degradation, or other aggravations of the original wrong, or else to punish the defendant for his evil behavior or to make an example of him . . . .

BLACK'S LAW DICTIONARY 390 (6th ed. 1990). For a discussion of the nature and effectiveness of punitive damages, see generally David G. Owen, *Civil Punishment and the Public Good*, 56 S. CAL. L. REV. 103 (1982).

[46] *See* LOUISELL & WILLIAMS, *supra* note 42, ¶ 4.02, at 4-2 (noting that "[a] physician is not an insurer of the results of his diagnosis and treatment"); *see also Boyce*, 77 P.2d at 457 (emphasizing that a presumption of negligence does not arise merely because the treatment rendered "was unsuccessful, failed to bring the best results, or [caused] the patient['s death]"); SYLVIA LAW & STEVEN POLAN, PAIN AND PROFIT 30 (1978) (observing that the term medical error is broader than the term medical malpractice because medical malpractice encompasses only those injurious medical errors that a reasonable physician would not commit); Jose Lozano, *Malpractice and the Health Care Crisis*, AM. MED. NEWS, Aug. 24, 1992, at 40, *available in* 1992 WL 11292224 (stressing that medical negligence should not be automatically equated with an adverse or bad outcome because unpleasant and undesirable results, including death, are often simply the side effects of many medications or pro-

Nor will a physician be held liable for an error in judgment if there exists a difference of opinion concerning the patient's medical condition or the proper treatment regimen, so long as the physician exercised reasonable care and skill.[47] The elements a plaintiff must prove to succeed in a medical malpractice case are similar to a typical negligence action.[48] Medical malpractice cases differ significantly from the typical negligence case, however, in that the plaintiff in the medical malpractice case is required to establish affirmatively the applicable standard of care through expert testimony.[49] Essentially, this means that the medical profession itself establishes the applicable standard of care.[50] The traditional "locality rule," which was used

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cedures).

[47] *See* BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 177 (2d ed. 1991) (noting that the "honest error in judgment doctrine" permits a physician to choose among several different methods of treatment that are accepted by the medical profession); LOUISELL & WILLIAMS, *supra* note 42, ¶ 9.05, at 9-34 to 9-35 (discussing the "honest error of judgment" defense that protects physicians from liability for an error in medical judgment where there exists multiple, reasonable courses of action); *see also* Roach v. Hockey, 634 P.2d 249, 252 (Or. Ct. App. 1981) (upholding the general rule that a physician is not liable for an honest error in judgment).

[48] *See* Dale L. Moore, *Disparate Treatment of the Allocation of Power Between Judge and Jury in Legal and Medical Malpractice Cases*, 61 TEMP. L. REV. 353, 355 (1988). Plaintiff must establish that the physician departed from the appropriate standard of care by proving "(1) the existence of a duty running from the physician to the injured party; (2) the physician's breach of this duty; (3) an injury to the patient that is proximately caused by the doctor's breach of duty; and (4) damages arising from the injury." LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.01, at 8-4 to 8-5.

[49] *See Boyce*, 77 P.2d at 457 (noting, however, that expert testimony is not required where the physician's "negligence is so grossly apparent that a layman would have no difficulty recognizing it"). To qualify as an expert witness in a medical malpractice case, the individual must establish, by her knowledge, training, skill, and education, that she can assist the trier of fact. *See* Hall v. Hilbun, 466 So. 2d 856, 873-74 (Miss. 1985). In most jurisdictions an expert witness is not required to be board certified in the area of practice for which she is testifying. *Cf.* Hanson v. Baker, 534 A.2d 665, 667 (Me. 1987) (upholding exclusion of medical expert testimony in a medical malpractice suit involving a head injury where the lower court excluded the testimony because the expert lacked experience and education in neurology, and not because the expert was not board certified). In fact, in some jurisdictions that take a liberal view, the witness is not even required to hold a medical degree so long as she possesses sufficient medical knowledge. *See* Thompson v. Carter, 518 So. 2d 609, 614 (Miss. 1987) (allowing a toxicologist to testify as to a drug's side effects). On the other hand, some jurisdictions adopt a narrow view requiring the expert to be trained in the relevant field and to have practiced in the same locale as the defendant. *See* Lundgren v. Eustermann, 370 N.W.2d 877, 880 (Minn. 1985) (holding that a licensed psychologist was not competent to provide expert testimony concerning the required standard of care of a medical physician).

[50] *See* Peter D. Jacobson, *Medical Malpractice and the Tort System*, 262 JAMA 3320, 3323 (1989). The conduct, or lack thereof, at issue in a medical malpractice case

to determine the standard of care, required a medical expert to compare the conduct of the defendant with that of reputable physicians in the same locality or similar community.[51] As a result of modern transportation, communication, and technology, courts abandoned the locality rule, recognizing that today the practice of medicine is national in scope.[52]

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concerns matters of scientific knowledge and expertise that are not generally within the realm of the typical juror. *See* LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.01, at 8-5. Therefore, in stark contrast to the typical negligence case, the custom of the medical profession almost exclusively determines the appropriate standard of care. *See* McCoid, *supra* note 39, at 606; Glen O. Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 173 (1986). One explanation for relying on the custom of the medical profession is that a standard established by other competent physicians enables the physician to make medical judgments based on her training, knowledge, and skill without the apprehension that "some outsider" will judge the medical decision in hindsight. *See id.* at 608.

[51] *See* HARNEY, *supra* note 22, at 412. This traditional standard of care is referred to as the locality rule and was established to protect rural and small town practitioners, who were often thought to be less adequately equipped and informed than practitioners from larger, urban areas. *See* Shilkret v. Annapolis Emergency Hosp. Ass'n., 349 A.2d 245, 248 (Md. Ct. Spec. App. 1975). The locality rule, however, has been modified and largely replaced by the national standard. *See* FURROW ET AL., *supra* note 47, at 134; *see also infra* note 52 and accompanying text (discussing the adoption of the national standard).

[52] *See* LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.04, at 8-34. For example, the Mississippi Supreme Court noted, in support of its decision to adopt the national standard, that the admissions standards at medical schools are similar; resident programs have substantially similar requirements; physicians have immediate access to current medical information through computer services, journals, and seminars; and physicians are more mobile today, attending medical school in one state, completing a residency in another, and establishing a practice in yet another state. *See Hall*, 466 So. 2d at 870; *see also Shilkret*, 349 A.2d at 249 (recognizing that new medical discoveries and techniques are now readily available to physicians in all areas of the country and further noting that the quality of medical schools has been standardized).

The *Hall* court recognized, however, that the main aspect of the locality rule, which takes into consideration the availability of medical equipment, facilities, and services, remains valid because the availability of medical resources differs around the country. *See* 466 So. 2d at 872 (noting, for example, that a hospital in a rural area may not have the equipment necessary to perform a CAT scan). Therefore, the duty of a physician to exercise the appropriate standard of care is "based upon the adept use of such medical facilities, services, equipment and options as are reasonably available." *Id.* (observing that in situations where the needed medical facilities are unavailable locally, but are "reasonably accessible" elsewhere, the physician is held to "minimally acceptable standards" of care that take into consideration factors such as the risk to the patient's health in effectuating a transfer, the trouble and expense of a transfer, and the superior facilities at the transferee institution). Specifically, the *Hall* court defined the national standard of care:

> [G]iven the circumstances of each patient, each physician has a duty to use his or her knowledge and therewith treat through maximum reasonable medical recovery, each patient, with such reasonable dili-

Just how effective medical malpractice is at compensating injured victims and monitoring quality control, however, is difficult to ascertain.[53] As to the first function, the disproportionately low number of injured people who actually file claims against health care professionals demonstrates that malpractice litigation falls short of compensating injured victims.[54] In addition, even when a claimant wins at trial, the award often does not fully compensate the injured party for the economic losses incurred through the litigation process.[55] Furthermore, although a general perception exists that juries are overly sympathetic to plaintiffs because of exorbitant cash judgments, the reality is that in an overwhelming majority of malpractice cases, the defendant-physician prevails.[56]

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> gence, skill, competence, and prudence as are practiced by minimally competent physicians in the same specialty or general field of practice throughout the United States, who have available to them the same general facilities, services, equipment, and options.

*Id.* at 873.

[53] *See, e.g.*, Jacobson, *supra* note 50, at 3320-21 (explaining that because malpractice data is not systematically collected, it is difficult to understand the precise relationship between tort awards and quality of care).

[54] *See* Meschievitz, *supra* note 9, at 126-28 (noting that of the 100,000 patients who suffered adverse events in New York state hospitals, the number of legal claims raised was only 125, and further noting that of the 14% of patients in Chicago hospitals who suffered serious injuries, defined as adverse events resulting in permanent disability or death, only 3% brought legal claims); *see also* Adler, *supra* note 7, at 688-89 (noting that during the mid-1980s, at the height of the medical malpractice crisis (see *infra* note 60 for a more detailed discussion of the medical malpractice crisis), only 1 in 10 incidents of negligent medical care amounted to the filing of a claim; only 1 in 25 claims actually received compensation; and only 1 in 7 incidents where a patient suffered permanent disability resulted in filing a claim); Rake & Thrasher, *supra* note 18, at 21 (reporting that, of the patients who are injured by negligent care at New York state hospitals, only one in eight filed legal claims).

[55] *See* Meschievitz, *supra* note 9, at 129 (citing empirical study documenting the number of medical malpractice claims arising from emergency room and obstetrical care in Florida between 1989 and 1990, as published in FRANK SLOAN ET AL., SUING FOR MEDICAL MALPRACTICE 6 (1993)). The study found that typically only 44% of an injured party's economic losses are covered. *See id.* Medical malpractice cases in which awards are in the million-dollar range are the exception and inflate the average award figure. *See* Rake & Thrasher, *supra* note 18, at 22; *see also* Kenneth Jost, *Still Warring Over Medical Malpractice Time for Something Better*, 79 A.B.A. J. 68, 71 (1993) (explaining that one study reported the average jury award as $367,737; however, the study pointed out that this number is distorted by a small percentage of large jury awards, and that the median award, which was only $36,500, is a better indicator of actual jury verdicts). Furthermore, while a few claimants win exorbitant awards in excess of their losses, such awards are often drastically reduced on appeal. *See* Jacobson, *supra* note 50, at 3323 (noting that courts reduced awards, on average, by 33%, but finding that awards greater than one million dollars were reduced, on average, by 39%).

[56] *See* Jacobson, *supra* note 50, at 3322; Jost, *supra* note 55, at 70 (referring to a study documenting that defendants won trials in 18 out of 19 cases where insurers

The concept that medical malpractice serves as a mechanism for quality control is also increasingly scrutinized.[57] Specifically, malpractice does not adequately monitor physician competence and, therefore, does not curtail the provision of incompetent medical care.[58] In theory, medical malpractice suits control the quality of health care by forcing physicians to take the necessary safety precautions in an effort to avoid compensating negligently injured patients.[59] The threat of litigation has traditionally provided little incentive for a physician to take precautions against the provision of negligent medical care because insurance companies pay malpractice claims.[60] Although physicians pay insurance premiums, these premiums are not generally based on the physician's professional record.[61] Rather, a physician's area of practice determines the appropriate premium.[62] As a result, medical malpractice litigation fails to

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anticipated a win, 13 out of 17 cases where the insurers thought the decision could go either way, and 6 out of 11 cases where insurer expected a loss). *But see* Lozano, *supra* note 46, at 40 (reporting that physicians suffer psychological trauma as a result of the process of malpractice litigation because they learn to see patients as potential threats and they come to view malpractice claims as judgments of their competence, rather than an inevitable part of the practice of medicine).

[57] *See, e.g.*, Adler, *supra* note 7, at 695-96 (discussing the problems with medical malpractice suits as a mechanism to control the quality of health care).

[58] *See id.*

[59] *See* Jost, *supra* note 5, at 572.

[60] *See* Adler, *supra* note 7, at 695. During the 1970s and again in the late 1980s, the United States witnessed what has been termed the "medical malpractice crisis." *See* PROSSER ET AL., *supra* note 36, at 196; Adler, *supra* note 7, at 684-89 (discussing the medical malpractice crisis). During those periods, the dramatic increase in the volume of medical malpractice suits produced sharp increases in insurance premiums. *See* PROSSER ET AL., *supra* note 36, at 196. The medical profession, growing increasingly alarmed, demanded that state legislators address the problem and curb the cost of insurance premiums. *See id.* Almost every state responded by passing legislation that limited a claimant's right to file a medical malpractice claim. *See id.* (noting, for example, that some states responded by changing the statute of limitations and limiting the amount of damages that could be awarded). It is beyond the scope of this Note to address the specific aspects of state legislation regarding medical malpractice, but see Nancy M. Simone, Note, *Medical Malpractice Litigation: A Comparative Analysis of United States and Great Britain*, 12 SUFFOLK TRANSNAT'L L.J. 577, 578-89 (1989), and LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.01, at 8-6 to 8-8 for a more detailed discussion.

[61] *See* Adler, *supra* note 7, at 695.

[62] *See id.* Most insurance companies charge physicians group, or community rated, premiums as opposed to experience rated premiums. *See* Jost, *supra* note 5, at 575; Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damage Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11, 54 (1991). Group premiums mean that the premium rate is based on group characteristics and location, whereas experience rated premiums mean that the premium price is based on the characteristics of a particular physician. *See id.* at 54, 57. Group premiums further insulate physicians from the

provide adequate deterrence to physicians from taking the necessary precautions to avoid incompetent treatment.[63]

### C. State Licensing Boards

Yet another mechanism for monitoring the competency of physicians is through state medical licensing boards.[64] State licensing boards have the authority to regulate the practice of medicine

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economic liability for medical errors because even a physician who is repeatedly sued for incompetence will not witness a rise in insurance premiums. *See id.* at 56. Some commentators argue that group premiums actually increase the incidence of malpractice because physicians in the group have little incentive to take precautions to avoid malpractice. *See id.* at 57. Furthermore, physicians with few incidents of malpractice are discouraged from staying in the group because they do not want to pay for risks that do not reflect their practice. *See id.* at 56.

[63] *See* Jost, *supra* note 5, at 575. The criticism that medical malpractice litigation is an inadequate mechanism to control the quality of health care because it does not deter incompetence has become less persuasive since the enactment of the National Practitioner Data Bank (NPDB) in 1990. *Cf.* Robert E. Oshel et al., *The National Practitioner Data Bank: The First 4 Years*, 110 PUBLIC HEALTH REPORTS 383, 383-84 (July-Aug. 1995). This is so because currently all payments regarding a medical malpractice claim made on behalf of a physician by an insurance company, whether for an award or a settlement, must be reported to the NPDB. *See id.* at 384; *see also infra* notes 107-122 (discussing the enactment and the requirements of the NPDB). Moreover, prior to hiring, contracting with, or extending staff privileges to a physician, health care entities must query the NPDB for information concerning the physician, as they will be deemed to have knowledge of such information. *See* 42 U.S.C. § 11135(a)(1) (1994). Therefore, even though third parties make payments on behalf of physicians, medical malpractice claims can have serious repercussions for physicians seeking staffing privileges at hospitals or contracts with managed care organizations. *See* Oshel et al., *supra*, at 384.

The enactment of the NPDB, however, does not completely rectify the inadequacies associated with medical malpractice litigation as a mechanism of quality control. First, because the NPDB "serves only as a flagging system," health care entities have been warned to view the information cautiously rather than automatically as a sign of a physician's incompetence. *See id.* at 384, 385. In addition, because a physician may debate the factual basis of the reports and include a statement explaining the accuracy of the report in the NPDB, *see id.* at 385, the increased deterrent effect, afforded by the mandatory reporting requirements, may not adequately deter a physician from failing in the first instance to take the necessary precautions to avoid malpractice claims. *Cf.* Adler, *supra* note 7, at 695. Finally, a very small percentage of patients who experience incompetent medical care actually pursue a medical malpractice claim. *See* Oshel et al., *supra*, at 384 (noting that "[l]ess than 2 percent of injuries caused by medical negligence in the hospital setting lead to malpractice claims, let alone payments"); *see also supra* note 54 (discussing statistical evidence on the percentage of medical malpractice claims pursued). For a more detailed discussion of the requirements and shortcomings of the NPDB, see *infra* notes 106-135 and accompanying text.

[64] *See* Kathleen L. Blaner, Comment, *Physician Heal Thyself: Because the Cure, The Health Care Quality Improvement Act, May be Worse Than the Disease*, 37 CATH. U. L. REV. 1073, 1079 (1988).

through their police power.[65] These boards may revoke a physician's license to practice medicine for malpractice,[66] gross negligence or malpractice,[67] professional incompetence,[68] or similar acts.[69] The reality is, however, that the revocation, or the suspension, of medical licenses for incompetence is extremely rare.[70] Instead, most of the

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[65] *See id.* at 1078 & n.31 (quoting Hawker v. New York, 170 U.S. 189, 192-93 (1898) (explaining that "[n]o precise limits have been placed upon the police power of a State, and yet it is clear that legislation which simply defines the qualifications of one who attempts to practice medicine is a proper exercise of that power.")). Historically, physicians who were respected in the community were appointed to serve on the state boards. *See id.* These state boards issued licenses to physicians deemed qualified to practice medicine and prevented unlicensed individuals, otherwise known as quacks, from practicing medicine. *See id.* As professional standards of conduct in the medical profession began to develop, the state boards were also charged with monitoring the competency of licensed physicians. *See id.* at 1078-79.

[66] *See* N.H. REV. STAT. ANN. §§ 329:17(VI)(c), (VII)(c) (1955 & Supp. 1996) (stating that New Hampshire's board may revoke licenses if it finds that the physician "[h]as displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof.").

[67] *See* ARK. CODE ANN. § 17-93-409(7) (Michie 1992 & Supp. 1992) (speaking of "[g]rossly negligent or ignorant malpractice"); N.J. STAT. ANN. § 45:9-16(h) (West 1991) (referring to "gross malpractice or gross neglect in the practice of medicine which has endangered the health or life of any person").

[68] *See* IOWA CODE ANN. § 147.55(2) (West 1989) (listing "[p]rofessional incompetency"); N.J. STAT. ANN. § 45:9-16(i) (specifying "professionally incompetent to practice medicine").

[69] *See* LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.01, at 8-6. Conduct that is subject to discipline in one state may not be subject to discipline in another state because states enjoy complete sovereignty in determining the professional standards required to obtain, and to maintain, a medical license in that particular state. *See* Blaner, *supra* note 64, at 1079-80.

[70] *See* Adler, *supra* note 7, at 692 (noting that even though state licensing boards have begun to discipline more physicians, the overall numbers remain small and unimpressive); William B. Schwartz & Daniel M. Mendelson, *The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence*, 262 JAMA 1342, 1345 (1989) (completing a study of 40 insurance companies owned by physicians, and noting that physicians are eight times more likely to lose their malpractice insurance for substandard care than they are to lose their licenses); *see also* H.R. REP. NO. 99-903, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385 (reporting that "[u]nfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so"). The Public Citizen's Health Research Group's (Public Citizens) analysis revealed that since 1993, of the 1622 physicians who were disciplined for incompetence or negligence nationwide, state licensing boards suspended only one-third, and revoked only 10%, of these physicians' licenses. *See* Stuart Auerbach, *Consumer Group Lists 'Questionable Doctors'; Insufficient Punishment for Bad Practice Leaves Patients at Risk, Says Group*, WASH. POST, Apr. 9, 1996, at Z7, *available in* 1996 WL 3073428 (referencing the Public Citizens' list of physicians who have been disciplined, titled "13,012 Questionable Doctors," which was published in May of 1996). Within a

serious disciplinary actions involve instances of providing inappropriate prescriptions or abusing drugs and alcohol.[71] These charges are easier for the board to prove than incompetence because the vast amount of evidence for such charges is collected by law enforcement authorities.[72]

There are several reasons for the overall ineffectiveness of state licensing boards in weeding out incompetent physicians and successfully monitoring the quality of health care.[73] To begin, state licensing boards are understaffed and underfunded.[74] One or two physicians contesting disciplinary actions could deplete the boards' limited budgets.[75] Additionally, many board members are uncomfortable with judging their peers, a dilemma that inevitably surfaces with self-policing systems.[76] Furthermore, the receipt of information

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week after the Public Citizens' publication, the Federation of State Medical Boards refuted criticism of its performance stating that within one year there had been over a seven percent increase in the number of serious penalties imposed against doctors. *See id.* Despite the increase in revocations and suspensions of physicians' licenses over the past five years, Public Citizens maintained that state boards were still not sufficiently protecting the public from substandard medical care. *See id.*

[71] *See* Adler, *supra* note 7, at 693 & nn.42-43 (citing OFFICE OF ANALYSIS AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, DEPT. OF HEALTH AND HUMAN SERVICES, MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW 16 (1986) (OIG Report); *see also* Steinbrook & Ellis, *supra* note 18, at 1 (reporting that one criticism of state licensing boards is that most disciplinary actions focus on egregious behavior, such as sexual misconduct with patients, prescribing drugs illegally, or bizarre treatments (e.g., the injection of urine to treat cancer) rather than negligent medical care because negligence is more difficult to prove).

[72] *See* Adler, *supra* note 7, at 693.

[73] *See id.* at 693-94.

[74] *See id.* at 693. For example, in 1990, the California Medical Board's yearly budget provided for the expenditure of $78 per licensed physician for enforcement purposes, as compared to the state bar's expenditure of $276 per attorney. *See* Steinbrook & Ellis, *supra* note 18, at 1. In addition, under-staffing created a six-month time delay between the request for a disciplinary hearing and when it was actually held. *See id.*

[75] *See* Adler, *supra* note 7, at 693 & n.47 (noting that a state licensing board's financial resources were significantly drained by a disciplinary proceeding that lasted four months and cost over $100,000 in legal fees).

[76] *See id.* at 693-94 & n.51 (citing an OIG Report that attributes this reaction to the "'brotherhood of silence,'" which refers to an "inherent resistance" to divulge information against one's peers coupled with a fear of legal liability for reporting such information); *see also* LAW & POLAN, *supra* note 46, at 29 (quoting an editorial by two physicians that stated: "'Every physician knows some colleague who has to be watched carefully, an old friend or even teacher for whom he hesitates to bring down the curtain even though he knows that the man or woman has advanced beyond his or her competence.'") (citation omitted). *But see* Blaner, *supra* note 64, at 1076 (detailing how the HCQIA seeks to end the "brotherhood of silence"); *infra* notes 118-35 and accompanying text (discussing the HCQIA).

concerning incompetent practitioners is sparse.[77] Information that is obtained is usually provided by law enforcement agents and consumers,[78] and not by other physicians, who are presumably the best sources of such information.[79] Furthermore, due process rights dis-

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[77] *See* Adler, *supra* note 7, at 694.

[78] *See id.* at 739 & n.252 (noting that, according to a 1986 OIG Report, consumer complaints are the major source of information for state licensing boards). *But see* Jost, *supra* note 5, at 585 (explaining that consumer complaints are frequently discouraged).

[79] *See* Adler, *supra* note 7, at 694 (explaining that the sources most likely to know about a physician's incompetence, but the least likely to report this information to boards, are hospitals, colleagues, medical societies, and peer review organizations); *see also infra* notes 91-99 and accompanying text (discussing peer review organizations). A Colorado state health-facilities director, responsible for overseeing patient safety at hospitals and nursing homes, explained that, except for fraud and abuse cases, there are no written policies for reporting cases to regulatory agencies involving unexpected deaths. *See* Michael Romano, *Unexpected Deaths Go Unpunished; No Disciplinary Action Taken in 90% of Cases at Hospitals, Nursing Homes in Colorado*, ROCKY MT. NEWS, Dec. 8, 1996, at 4A, *available in* 1996 WL 12360203. Rather, whether such cases are referred to the correct authorities for investigation is left to "professional discretion." *See id. But see* Jost, *supra* note 5, at 585 (noting that states have enacted legislation mandating that medical professionals report incidents of incompetence and providing immunity for those professionals who report). For example, in New Jersey the law provides:

> a. A physician or medical resident or intern, or podiatrist, hereinafter referred to as a "practitioner," shall promptly notify the State Board of Medical Examiners if that practitioner is in possession of information which reasonably indicates that another practitioner has demonstrated an impairment, gross incompetence or unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety or welfare. A practitioner who fails to so notify the board is subject to disciplinary action and civil penalties pursuant to sections 8, 9, and 12 of P.L. 1978, c.73 (C:45:1-21 to 22 and 45:1-25).
>
> b. There shall be no private right of action against a practitioner for failure to comply with the reporting requirements of this section.
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> c. A practitioner who notifies the board about a practitioner who is impaired or grossly incompetent or who has demonstrated unprofessional conduct pursuant to this section is not liable for damages to any person for notifying the board unless the practitioner knowingly provided false information to the board.
>
> d. Notwithstanding the provisions of this section to the contrary, a practitioner is not required to notify the board about an impaired or incompetent practitioner if he has knowledge of the practitioner's impairment or incompetence as a result of rendering treatment to the practitioner.

N.J. STAT. ANN. § 45:9-19.5 (West 1991). The state mandatory reporting laws generally do not completely cure the lack of reporting of incompetent physicians because the requirements of the statutes are vague and the penalties for failure to report are minimal. *See* Jost, *supra* note 5, at 585. Furthermore, when the person reporting is the supervisee, or close friend of the incompetent physician, the statutes are unlikely to have much effect. *See id.*

courage pursuing physicians without good evidence.[80] Finally, lengthy delays in the system render the threat of sanctions a remote possibility, thereby undermining the ability of state licensing boards to deter incompetent behavior.[81]

In addition to these obstacles, there is concern that state licensing boards spend an inordinate amount of time and resources rehabilitating incompetent physicians rather than imposing sanctions to the full extent.[82] On the other hand, some argue that the state boards are ineffective because the penalties are too drastic and, as a result, the boards rarely impose the available sanctions.[83] Further, many states' licensing boards have agreed to forgo disciplinary actions against a physician in return for the physician's promise never to practice in the state again.[84] As a result of such compromises, the incompetent physicians leave the state and simply continue to practice in another state.[85] Even when a state licensing board does take

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[80] *See, e.g.*, Franz v. Board of Med. Quality Assurance, 642 P.2d 792, 797, 800 (Cal. 1982) (maintaining that record must provide sufficient evidence to allow for judicial review and concluding that board's evidence was insufficient to support finding that physician was grossly negligent); Leone v. Division of Med. Quality, Nos. B103344, B101297, 1997 WL 587303, at *1, *4 (Cal. Ct. App. Sept. 24, 1997) (holding that state statute denying physicians direct appeal from superior court's affirmation of state licensing board's disciplinary action was unconstitutional because physicians have the constitutional right to appellate review to determine sufficiency of evidence in the record).

[81] *See* Jost, *supra* note 5, at 586-87; *see also, e.g.*, Steinbrook & Ellis, *supra* note 18, at 1 (reporting that the California State Licensing Board had over 600 patient complaints waiting to be investigated, and that once assigned, the investigations would last up to four years).

[82] *See* Auerbach, *supra* note 70, at Z7 (reporting that the director of Public Citizens argued, "Medical Boards are much too forgiving. Many still see their priority as rehabilitation, and their disciplinary actions are too light."); Steinbrook & Ellis, *supra* note 18, at 1 (noting that the president of an organization that represents over half of the physicians in California opined that the board was simply "not tough enough"); *see also* Jost, *supra* note 5, at 583 (explaining that although state licensing boards have the authority to revoke physicians' medical licenses, they are unlikely to resort to such a severe sanction in a case of incompetency).

[83] *See* Jost, *supra* note 5, at 586. Some commentators argue that if state licensing boards had the authority to impose intermediate disciplinary sanctions, such as retraining and counseling, the boards would be more effective in monitoring incompetent physicians. *See* Auerbach, *supra* note 70, at Z7 (quoting a professor, and former surgeon, of Harvard University's School of Public Health who observed: "Everyone thinks it is an all-or-nothing situation in which a doctor should lose his license if he makes a mistake. We don't treat anyone else like that.").

[84] *See* Adler, *supra* note 7, at 691.

[85] *See* Auerbach, *supra* note 70, at Z7; *see also* Adler, *supra* note 7, at 691-92 (reporting that, according to the General Accounting Office, out of 122 physicians disciplined by state licensing boards, 49 physicians continued their practice after relocating to another state); Blaner, *supra* note 64, at 1081 & n.58 (reporting that a

disciplinary action against a physician and the information about the final disciplinary action is made available to the public, acquiring that information is often difficult and time consuming.[86]

In sum, state medical licensing boards do afford some protection against inadequate medical care by requiring physicians to possess minimum qualifications.[87] This is where the protection ends, however, because once physicians have their licenses, state licensing boards tend to be ineffective at removing physicians who fail to retain these minimum qualifications.[88] Therefore, state licensing

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bargain was made between the Pennsylvania Licensing Board and an incompetent physician in which the board agreed to forgo imposing disciplinary action against the physician in exchange for the physician's promise to cease practicing medicine in the state). *But see infra* notes 100-35 and accompanying text (discussing HCQIA and the NPDB—federal legislation enacted to curtail relocating from state to state).

[86] *See, e.g.*, Steinbrook & Ellis, *supra* note 18, at 1 (reporting that due to understaffing and ill-equipped phone systems, a consumer calling a state licensing board is likely to get a busy signal); *see also* Sarah Glazer, *How Much Do You Know About Your Doctor?*, WASH. POST, Mar. 5, 1991, at Z10, *available in* 1991 WL 2152699 (noting that an investigator for the California Medical Board advises consumers to visit the local courthouse and examine the civil suit index to see if there are any pending or final judgments against their physicians).

Even when consumers are able to contact the state board, the information they obtain from the board may be of little value. *See id.* (providing an example of a woman who, when debating whether to have cosmetic surgery, decided to contact the state medical board about her prospective surgeon and was told that there was no negative information on the doctor). Believing the surgeon to be competent, the woman had the operation, which resulted in a post-surgical infection that threatened her life. *See id.* The board failed to tell her that the surgeon had been under investigation by the board for over two years and had 11 malpractice suits filed against him. *See id.* This information was not revealed because the state board, like most state boards in the country, had a policy of not revealing information regarding pending medical malpractice suits, consumer complaints, or investigations, unless they resulted in an official conclusion of guilt by the board. *See id.* (reporting that the president of the AMA justified the policy of silence based on the "innocent until proven guilty" theory of the American legal system).

The problem of acquiring information about incompetent physicians has been somewhat alleviated for hospitals and state licensing boards by the establishment of the NPDB, which, pursuant to the HCQIA, requires that disciplinary actions taken against physicians be reported; however, consumers do not have access to this information. *See* Frances H. Miller, *Illuminating Patient Choice; Releasing Physician-Specific Data to the Public*, 8 LOY. CONSUMER L. REP. 125, 126-28 & n.15 (1995-96) (noting that while the NPDB fails to provide information to the general public, the State of Massachusetts has established alternative procedures for such disclosure); *see also infra* notes 109-35 and accompanying text (discussing the NPDB).

[87] *See* FURROW ET AL., *supra* note 47, at 102.

[88] *See id.* One example of the inadequacy and dangers of current state disciplinary systems is the case of Dr. Milo Klvana, an obstetrician who was convicted of second-degree murder in 1990 for the deaths of a fetus and eight newborns. *See* People v. Klvana, 15 Cal. Rptr. 2d 512, 514-16 (Ct. App. 1993), *habeus corpus denied sub nom.* Klvana v. California, 911 F. Supp. 1288, 1299 (C.D. Cal. 1995). The atrocity of the case was exacerbated by evidence that Dr. Klvana's incompetence had been

boards do little to assure the optimal level of quality care for patients.[89]

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accumulating for years without a proper investigation. *See* Steinbrook & Ellis, *supra* note 18, at 1.

Dr. Klvana, who obtained a medical degree in Czechoslovakia, failed to complete his fourth year of residency at a New York medical center because he performed poorly on the Council on Resident Education in Obstetrician and Gynecology Examination and improperly administered medication. *See Klvana*, 15 Cal. Rptr. 2d at 515. These deficiencies precluded Dr. Klvana from becoming the chief resident at the medical center and prevented him from taking the board certification examination for obstetrics. *See id.* Despite these events, however, Dr. Klvana was granted a California medical license and was accepted into a two-year residency program in anesthesiology at a California university hospital. *See id.* When the faculty at the university hospital determined that Dr. Klvana was performing incompetently, Dr. Klvana resigned from the residency program. *See id.* (noting that one faculty member explained that Dr. Klvana was "cavalier and casual in his approach and his duties, not performing them in a manner that really would indicate the utmost care for his patients"). The medical staff recommended that Dr. Klvana avoid practicing medicine in those areas where the patient's safety is an issue on a moment-to-moment basis. *See id.* Subsequently, Dr. Klvana was granted staff privileges at another California hospital after having misrepresented to the hospital that he was board certified in obstetrics and gynecology. *See id.* When the hospital voiced its concern over the abnormally high number of premature infants born under Dr. Klvana's care and required him to obtain second opinions for his patients, Dr. Klvana resigned. *See id.* at 515-16. Dr. Klvana continued this pattern of applying for staff privileges at area hospitals until he opened his own clinic. *See id.* at 516.

Dr. Klvana was eventually placed on probation for five years by the California Medical Board for the incorrect use of a labor-inducing drug. *See id.* at 516 n.7. The Board reduced his probation by three years, however, and failed subsequently to monitor the doctor. *See* Steinbrook & Ellis, *supra* note 18, at 1. The newborn deaths for which Dr. Klvana was charged with murder were attributed to Dr. Klvana's improper use of a labor-inducing drug. *See id.* When the California Medical Board finally commenced an investigation into the deaths, the Board relied heavily on Dr. Klvana's own account of the incidents and ignored the opinion of medical experts who found Dr. Klvana's practice to be grossly negligent. *See id.* Furthermore, the Board took no action to prevent Dr. Klvana from practicing until he had already been in prison for over a year. *See id.*

After sentencing Dr. Klvana to fifty-three years in prison, Judge Chirlin chastised the California Medical Board, stating that the Board was partially responsible for the deaths because of its failure to perform its function—protecting the public by monitoring incompetent physicians. *See id.* Judge Chirlin further declared the case "'a testament to the abject failure'" of the California Medical Board *See id.* In response to the judge's criticism, the president of the Board explained, "You will always find an outlandish case or a problem case, something that could go through the cracks," but insisted that California did not have a "big problem" with disciplining physicians. *Id.*

[89] *See* FURROW ET AL., *supra* note 47, at 102; *see also* LOUISELL & WILLIAMS, *supra* note 42, ¶ 8.01, at 8-6 (suggesting that the expansion of malpractice law is a product of state licensing boards' ineffectiveness in monitoring and preventing medical negligence).

*D. Professional Disciplinary Systems*

The professional disciplinary systems offer an additional mechanism to regulate the quality of health care.[90] Specifically, the medical profession has long relied on peer review to monitor the professionalism of physicians' conduct.[91] Peer review is essentially a self-regulating police system in which committees of physicians review and evaluate the quality of their colleagues' work.[92] Ultimately, the goal of peer review is to protect patients from poor medical care by having other physicians, who possess the requisite expertise necessary to make an informed judgment, determine what constitutes a deficient pattern of medical care and what warrants disciplinary actions.[93] In the United States, most physicians are subject to some form of peer review.[94]

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[90] *See* Adler, *supra* note 7, at 696.

[91] *See id; see also* Erich H. Loewy, *Guidelines, Managed Care, and Ethics*, 156 ARCHIVES OF INTERNAL MED. 2038, *available in* 1996 WL 8987263 (1996) (noting that, initially, peer review committees met resistance from physicians; however, strong pressures outside the profession forced the adoption of this form of self-policing).

[92] *See* Adler, *supra* note 7, at 696. Peer review is "the evaluation by practicing physicians of the quality, efficiency and effectiveness of services ordered or performed by other physicians." WILLIAM P. ISELE, THE HOSPITAL MEDICAL STAFF; IT'S LEGAL RIGHTS AND RESPONSIBILITIES 126 (1984).

[93] *See* Paul L. Scibetta, Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1032-33 (1990).

[94] *See* Adler, *supra* note 7, at 696-97 (noting that because Medicare mandates peer review when physician services are reimbursed, most physicians undergo some form of peer review); *see also* Jost, *supra* note 5, at 542-43 & n.108, 554 (explaining that state law and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a body that accredits health care institutions, require quality assurance programs to evaluate physicians who practice within these institutions).

One form of peer review practiced at most hospitals in the United States is "the medical staff privilege system." *Id.* at 554. In most hospitals throughout the United States, physicians are independent contractors, as opposed to hospital employees, and must be granted staff privileges to admit patients to the hospital. *See id.* at 553-54. The hospital's governing board grants staff privileges based on the existing medical staff's recommendation. *See id.* at 554. Once on the medical staff, a physician's practice is periodically monitored to detect patterns of unacceptable care. *See id.* If an unacceptable pattern of care is detected, a peer review committee, composed of physicians who generally are volunteers, investigates the problem and makes recommendations concerning possible disciplinary actions, such as requiring further education, supervising the physicians, or even revoking staff privileges. *See* Scibetta, *supra* note 93, at 1032-33.

In addition to hospital peer review, the Health Care Financing Administration (HCFA) contracts with Peer Review Organizations (PROs) to review the quality of physicians' care provided to Medicare patients. *See* Peter E. Dans et al., *Peer Review Organizations; Promises and Potential Pitfalls*, 313 NEW ENG. J. MED. 1131, 1131-32 (1985); R. Heather Palmer, *Quality Health Care*, 275 JAMA 1851, 1851 (1996). Usu-

Despite the goal of peer review to detect and correct poor medical care, peer review's contribution to assuring quality care is limited.[95] Several reasons explain why the peer review system is often an ineffective mechanism for monitoring incompetent physicians. To begin, many physicians are firm believers in the adage "'there but for the grace of God go I'"[96] and consequently tend to be extremely adverse to passing judgment on their colleagues' professional conduct.[97] Furthermore, physicians on peer review committees must volunteer their time; they are not financially compensated.[98] In addition, the threat of litigation provides a strong disincentive to serve on peer review committees.[99]

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ally, local physicians comprise the PROs, and in some instances the state medical societies own the PROs. *See id.* PROs monitor the provision of health care by reviewing patient profile data, beneficiaries complaints, and medical records. *See* Timothy Stoltzfus Jost, *Policing Cost Containment: The Medicare Peer Review Organization Program*, 14 U. PUGET SOUND L. REV. 483, 498 (1991). When a quality problem is detected, the responsible physician, or health care institution, must adhere to a "corrective action plan," which often requires further education, training, and monitoring. *See id.* at 499. If the institution or physician fails to comply with the corrective action plan, the PRO may recommend to the Inspector General's Office of the Department of Health and Human Services (HHS) that sanctions be taken, either in the form of civil fines or exclusion from the medicare program. *See id.* For a detailed discussion and critical assessment of PROs see generally Jost, *supra*, at 486-526.

In the area of managed care, a system called utilization review (UR) is used to monitor the provision of medical treatment by physicians. *See* Brian P. Battaglia, *The Shift Toward Managed Care and Emerging Liability Claims Arising From Utilization Management and Financial Incentive Arrangements Between Health Care Providers and Payers*, 19 U. ARK. LITTLE ROCK L.J. 155, 170 (1997). Typically in the UR process, registered nurses review subscribers' cases to determine whether the proposed care falls within the managed care organization's utilization standards. *See id.* at 172. If it is determined that the treatment does not fall within the utilization standards, the case is referred to UR physicians for further analysis. *See id.* UR serves several functions, including monitoring medical professionals' practice patterns for both cost containment and quality of care purposes. *See id.* at 171.

[95] *See* Jost, *supra* note 5, at 554.

[96] Adler, *supra* note 7, at 697.

[97] *See id.* Essentially, physicians can empathize with the serious consequences of revoking a colleagues' staff privileges or medical license; this may explain why physicians on peer review committees are often hesitant to press for disciplinary action. *See id.*

[98] *See id.* (explaining that physicians who participate in peer review committees "make neither money nor friends").

[99] *See id.* In the past, physicians disciplined by peer review committees have sued committee members for defamation, malicious interference with contractual relations, and denial of due process. *See id.* at 697-98; *see also, e.g.*, McMorris v. Williamsport Hosp., 597 F. Supp. 899, 900, 917 (M.D. Pa. 1984) (involving a doctor that brought action against physicians, hospital, and board of trustees alleging, among other things, that the defendants interfered with the physician's contractual relation when they removed him from the directorship of his department); Maimon

Congress enacted the Heath Care Quality Improvement Act of 1986 (HCQIA)[100] to combat some of the problems outlined above.[101] Specifically, the HCQIA seeks to encourage physicians to participate in peer review by providing immunity from damages under any state or federal law.[102] Immunity under the HCQIA extends to "peer re-

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v. Sisters of the Third Order, 491 N.E.2d 779, 784 (Ill. App. Ct. 1986) (concerning hospital that followed procedure set forth in its bylaws for the expulsion of a hospital staff member; therefore exclusion did not violate due process); Hayden v. Foryt, 407 So. 2d 535, 536-38 (Miss. 1981) (comprising situation where staff anesthetist sued chief anesthetist and hospital for damages resulting from alleged defamation after chief anesthetist reported the staff anesthetist's incidents of inadequate care).

To encourage peer review, a number of states enacted "shield laws" aimed at providing immunity for those physicians who serve on peer review committees. *See* Adler, *supra* note 7, at 698 & n.77 (citing *The Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540, Before Subcomm. on Civil and Constitutional Rights of the House Committee on Judiciary*, 99th Cong. 75 (1986) (statement of Marilyn C. Furay)); *see also* Scibetta, *supra* note 93, at 1084 n.28 (citing several state "shield laws" that provide varying degrees of immunity). Physicians denied staff privileges based on the recommendation of peer review committees countered state shield laws by filing antitrust lawsuits claiming anticompetitive abuses. *See* Adler, *supra* note 7, at 697-98. In *Patrick v. Burget*, 486 U.S. 94 (1988), the best known case in this area, *see* Adler, *supra* note 7, at 698 n.79, the Supreme Court upheld a judgment of nearly two million dollars against a peer review organization that abused the review process in an effort to exclude the plaintiff-physician from the local market. *See Burget*, 486 U.S. at 98, 105-06. See also Adler, *supra* note 7, at 698 n.79 for citations of additional antitrust cases.

[100] 42 U.S.C. §§ 11101, 11111-11152 (1994). See Adler, *supra* note 7, at 700-17 for a detailed analysis of the legislative history of the HCQIA.

[101] *See* Pauline Martin Rosen, Comment, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 LOY. L.A. L. REV. 357, 361 (1993) (noting that Congress enacted the HCQIA to combat criticism of the peer-review system used to self-police the medical profession); Louise M. Joy, Comment, *The Health Care Quality Improvement Act of 1986: A Proposal for Interpretation of Its Protection*, 20 ST. MARY'S L.J. 955, 962-63 (1989) (explaining that the goal of the HCQIA is to encourage physicians to participate in peer review).

[102] *See* Robert E. Kuelthau, *Ambulatory Surgery Centers—Medical Clinics and the National Practitioner Data Bank*, 79 MARQ. L. REV. 819, 820 (1996). In pertinent part, the HCQIA provided the following congressional findings:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
>
> (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
>
> (3) This nationwide problem can be remedied through effective professional review.
>
> (4) The threat of private money damage liability under Federal Laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
>
> (5) There is an overriding national need to provide incentive and pro-

view actions"[103] taken against physicians and not to peer review actions taken against other health care professionals, such as nurses.[104] Furthermore, the immunity provision applies only when the "peer review board"[105] takes action against a physician for unprofessional conduct or incompetence.[106]

In addition to the immunity provision, the HCQIA also includes a mandatory reporting provision.[107] The mandatory reporting provision was included to combat the pervasive problem of incompetent physicians resigning from health care institutions and continuing their practice elsewhere before disciplinary actions could be taken against them.[108] Congress established the National Practitioner Data

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tection for physicians engaging in effective professional peer review.

42 U.S.C. § 11101. The HCQIA provides that persons participating in peer review actions that meet the requirements of the statute "shall not be [held] liable in damages under any law of the United States or any State (or political subdivision thereof) with respect to the action." *Id.* § 11111(a). The HCQIA immunity does not extend to damages under state or federal laws relating to civil rights. *See id.* Furthermore, the immunity provision applies only to private antitrust suits, as the Attorney General retains the power to bring an antitrust action. *See id.*

[103] Peer review action, or more specifically "professional review action," is defined in the HCQIA to mean

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

42 U.S.C. § 11151(9).

[104] *See* FURROW ET AL., *supra* note 47, at 817. Although not required, the HCQIA also permits health care entities to report peer review actions taken against health care professionals other than physicians if the underlying conduct would require reporting if committed by a physician. *See* Adler, *supra* note 7, at 733 & n.232; *see also infra* note 112 (discussing reportable peer review actions).

[105] The term peer review board, or more specifically "professional review body," is defined as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C. § 11151(11).

[106] *See id.* § 11151(9). Specifically excluded from the definition of peer review actions are a physician's membership, or lack of membership, in a professional society, fees and advertising, employment status in group health plans, association with a private group practice, and any other activity not based upon the physician's professional conduct or competence. *See id.*; *see also* Henry A. Waxman, *Sounding Board Medical Malpractice and Quality of Care*, 316 NEW ENG. J. MED. 943, 943 (1987) (explaining that the HCQIA immunity provision extends only to physicians disciplining other physicians through the peer review system for incompetence, and then only if the procedures used were fair).

[107] *See* 42 U.S.C. §§ 11131-11137.

[108] *See* Waxman, *supra* note 106, at 943; *see also* Karen Sandrick, *Two Years and*

Bank (NPDB)[109] to gather and provide information regarding disciplinary actions taken against physicians.[110] Health care entities[111] and state licensing boards that conduct peer review activities are required to report information regarding peer review actions taken against physicians for incompetent or unprofessional conduct.[112] In addi-

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*Running the National Practitioner Data Bank Begins to Roll, But Issues Remain*, HOSPITALS, Feb. 5, 1993, at 44 (noting that the mandatory reporting requirement of the HCQIA in the first two years resulted in disciplinary action taken against an estimated 6000 "gypsy physicians" (physicians who move from one state to the next to avoid disciplinary actions)). The legislative history of the HCQIA found that "[e]ven when [licensing boards and hospitals] do act against bad physicians, these physicians find it all to easy to move to different hospitals or states and continue their practices in these new locations." H.R. REP. NO. 99-903, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385.

[109] *See* 42 C.F.R. § 60 (1994). The NPDB began operation on September 1, 1990. *See* Oshel et al., *supra* note 63, at 383. The Division of Quality Assurance, Bureau of Health Professions, Health Resource and Services Administration, Public Health Service oversees the NPDB program. *See id.*

[110] *See* 42 C.F.R. § 60.1.

[111] The term "health care entity" is broadly defined by the act and includes third party payers. *See* 42 U.S.C. § 11151(4)(A). Pursuant to the HCQIA, the term "health care entity" includes the following:

> (i) a hospital that is licensed to provide health care services by the State in which it is located,
> (ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care . . . , and
> (iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care . . . .

*Id.*

[112] *See* Kuelthau, *supra* note 102, at 819. Within 15 days after a reportable peer review action, the health care entity must submit a NPDB Adverse Action Report (NPDB report), which includes the physician's name and a description of the reason for taking the action. *See id.* at 827. Peer review actions are reportable if:

> A physician's application for medical staff appointment is denied based on the professional competence or conduct. (However, a denial based upon failure to meet the initial credentialing criteria applied to all medical staff or clinical privilege applicants is not reportable.)
>
> A physician's request for clinical privileges is denied or restricted, based upon an assessment of his or her current clinical competence as defined by the health care entity.
>
> A physician voluntarily restricts or surrenders his clinical privileges while his professional competence or conduct is under investigation, or in return for an agreement not to conduct an investigation of his professional competence and/or conduct.
>
> Based on an assessment of his professional conduct, a proctor is assigned to a physician and the physician must be granted approval by the proctor before certain medical care is administered.
>
> Although not specifically set forth as an example in the Guide-

tion, information concerning medical malpractice settlements and payments must be reported.[113] Failure to report a peer review action could result in the loss of the health care entity's peer review immunity.[114] Moreover, it is the duty of each health care entity to request information from the NPDB prior to extending staff privileges or employing physicians[115] and to review information every two years re-

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> book, it is likely that the denial of membership in a medical clinic based on professional competence or conduct would also be a reportable action.

*Id.* at 826 (quoting U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PRACTITIONER DATA BANK GUIDEBOOK E-22-23 (1994) [hereinafter GUIDEBOOK]). Peer review actions are non-reportable if:

> Based on an assessment of [a physician's] professional competence, a proctor is assigned to supervise a physician, but a proctor is not required to grant approval before medical care is provided by the physician.
>
> If a physician voluntarily restricts or surrenders his clinical privileges for personal reasons when his professional competence and/or conduct is not under investigation.
>
> If a physician is denied medical staff appointment or clinical privileges because the health care entity already has too many specialists in the individual's discipline.
>
> If a physician's privileges are suspended because of failure to complete a patient's chart in accordance with the health care entity's policy.

*Id.* at 826-27 (quoting GUIDEBOOK, *supra*, at E-22-23). NPDB reports are submitted by the health care entity to the state medical board with the authority to monitor and discipline physicians. *See id.* at 827. Within 15 days after receiving a NPDB report, the state board is responsible for forwarding the report to the NPDB. *See id.* (citing 45 C.F.R. § 60.5(c)). Within 30 days, state medical boards must report licensure actions relating to a physician's professional conduct or competence that (1) suspend or revoke the license; (2) place on probation, reprimand, or censure the physician; and (3) require the physician to surrender the license. *See* 45 C.F.R. §§ 60.5(b), 60.8(a).

[113] *See* FURROW ET AL., *supra* note 47, at 55. The HCQIA requires any entity, even if not otherwise subject to the provisions of the Act, to report any "payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim" made for the benefit of a physician. 42 U.S.C. § 11131(a) (explaining that insurance companies fall under the medical malpractice reporting provision). The information must be reported to the NPDB within 30 days after the date payment was made. *See* 45 C.F.R. § 60.5(a). Physicians argue that the malpractice information contained in the NPDB is incomplete because it fails to take into account the purely economic reasons that may force a physician to agree to a settlement. *See* Brian McCormick, *It's Baaaaaaack; Clinton Would Open Data Bank After All; Name 'Repeat Offenders,'* AM. MED. NEWS, Dec. 6, 1993, at 2, *available in* 1993 WL 12219323.

[114] *See* Kuelthau, *supra* note 102, at 827. A health care entity is given notice when it fails to submit the report and is provided with an opportunity to rectify the failure. *See id.* However, if the problem persists, the health care entity will lose its immunity regarding peer review actions for three years. *See id.*

[115] *See* 42 U.S.C. § 11135(a)(1).

garding the entire medical staff.[116] It is important that the health care entity fulfill its duty to obtain information because it is presumed to have knowledge of the information reported to the NPDB regardless of whether it actually obtains the information.[117]

The HCQIA also contains a provision addressing disclosure and confidentiality requirements.[118] A physician can request the information in his or her file and can dispute the accuracy of the information.[119] In addition, upon request, information is disclosed to state licensing boards, hospitals, and other health care entities, including managed care organizations (MCOs) that are contemplating, or have already entered into, an employment or affiliation arrangement with a physician.[120] In general, the information reported to the NPDB is confidential and will only be disclosed if requested for peer review activities that further the quality of health care.[121] Violation of the confidentiality provision of the HCQIA could result in serious civil penalties.[122]

Although the enactment of the HCQIA, which established the NPDB, was a major advancement towards assuring quality health care, the HCQIA is not the final solution towards identifying and disciplining incompetent physicians.[123] Health care entities and state licensing boards are still ultimately responsible for monitoring or removing incompetent doctors from the medical profession.[124] The HCQIA does not provide a mechanism for disciplining physicians; it

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[116] *See id.* § 11135(a)(2).

[117] *See id.* § 11135(b).

[118] *See id.* §§ 11136-11137.

[119] *See id.* § 11136. *See generally* Diane M. Gianelli, *Practitioner Data Bank Begins Sept. 1; Confidentiality Remains Key Concern*, AM. MED. NEWS, July 27, 1990, at 1, *available in* 1990 WL 3259802 (discussing procedures available to physicians for disputing information contained in their NPDB files).

[120] *See* 42 U.S.C. § 11137(a).

[121] *See id.* § 11137(b)(1), (3). Information that does not identify the physician, patient, or health care entity is not deemed confidential. *See id.* § 11137(b)(1).

[122] *See id.* § 11137(b)(2) (for each violation, a person will be subject to a civil fine up to $10,000). When asked what mechanisms are in place to prevent a plaintiff's attorney or an insurance company from pretending to be an entity authorized to have access to information in the NPDB, a doctor for the Health Resources Services Administration, a division of HHS, responded, "Only the chance that they will be caught." Gianelli, *supra* note 119, at 1. The doctor explained, however, that those unauthorized to request information would likely be caught because, at a physician's request, the NPDB discloses the names of persons and entities requesting that physician's information. *See id.*

[123] *See* Oren L. Zeve, *Physician Discipline: Considerations for National Policy*, 13 IN PUB. INTEREST 1, 26-27 (1993).

[124] *See* Adler, *supra* note 7, at 737.

merely provides immunity for peer review to health care entities and state licensing boards.[125] Furthermore, because the HCQIA does not require that all adverse information be reported to the NPDB, health care entities can circumvent the reporting requirement by sanctioning incompetent physicians such that the disciplinary action need not be reported.[126]

The general public cannot obtain information contained in the NPDB[127] nor can consumers report information concerning inade-

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[125] *See id.* at 737-38.

[126] *See* 42 U.S.C. § 11133 (a)(1)(A). The HCQIA requires health care entities to report any "professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days." *Id.* Therefore, one way a health care entity can circumvent the reporting requirement is to discipline a physician for less than 30 days. *See* Zeve, *supra* note 123, at 26 (noting that one gap in the HCQIA is the exclusion of disciplinary sanctions under thirty days).

[127] *See* Miller, *supra* note 86, at 126; *see also* FURROW ET AL., *supra* note 47, at 55 (noting that in very limited circumstances, plaintiffs' attorneys can gain access to information in the NPDB). As discussed previously, information regarding state licensing boards' disciplinary actions is generally available to consumers, although it can prove to be very time consuming and difficult to obtain. *See supra* note 86 and accompanying text. The New York State Board of Regents recently made licensing and disciplining information concerning physicians, among other professionals, available to consumers via the Internet. *See* Dan Barry, *Questions About a Professional's Standing? An Answer's on the Web,* N.Y. TIMES, Feb. 2, 1997, at L31. In addition, a hyperlink to the New York State Health Department's Office of Professional Medical Conduct, accessible from the education department's web site, allows consumers to access information concerning a physician's disciplinary history. *See id.* Other states, including Massachusetts and Texas, provide similar information to consumers. *See id.* In 1994, Massachusetts's Secretary of Consumer Affairs appointed an advisory committee to determine what information should be disseminated to the general public in response to allegations that the State Board of Registration in Medicine was too lenient, and that the non-disclosure policy concerning physicians was no longer a wise policy. *See* Miller, *supra* note 86, at 127. The committee identified four broad disclosure categories: (1) education and training, (2) malpractice claims history, (3) disciplinary sanctions by the licensing board and hospitals, and (4) criminal convictions. *See id.* at 128-33. For a detailed discussion of Massachusetts's disclosure systems, see generally Jeffrey P. Donohue, *Developing Issues Under the Massachusetts 'Physician Profile Act,'* 23 AM. J.L. & MED. 115 (1997). It has been suggested that, because the NPDB contains information similar to that found in state licensing and disciplinary reports, there is no valid reason to prohibit disclosing this information to the public. *See* Adler, *supra* note 7, at 739-40 (proposing the establishment of a national toll-free hotline whereby consumers could phone the NPDB for information concerning their physician). At one point, the Clinton Administration proposed to open the NPDB to the public regarding physicians who settled multiple medical malpractice claims. *See* McCormick, *supra* note 113, at 2; *see also* Ann Schrader, *Doctor-Data Demand Grows; Deaths Fuel Public Outcry,* DENV. POST, Sept. 17, 1995, at A1, *available in* 1995 WL 10197583 (reporting that in 1995, United States Representative Ron Wyden (D-Or.) planned to propose opening the NPDB to the public).

quate health care they may have received.[128] Therefore, consumers remain at the mercy of health care entities and state licensing boards to protect them from incompetent physicians.[129] The father of a little

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[128] *See* Adler, *supra* note 7, at 739 (noting that, with the exception of malpractice claims that end in a settlement or award and disciplinary actions by state licensing boards pursuant to patient complaints, a consumer cannot register a complaint with the NPDB).

[129] An investigator for a state licensing board cautioned that consumers should be wary of physicians who do not have hospital staff privileges, explaining that "it's always the bad ones" who do not have privileges. Glazer, *supra* note 86, at Z10. A devastating example of the HCQIA's inability to cure the problems of peer review is the case of Dr. Joseph Verbrugge. *See* Bensel & Goldberg, *supra* note 3, at B10. Dr. Verbrugge, an anesthesiologist in Colorado, was charged with reckless manslaughter in connection with the death of an eight-year-old boy. *See id.*; *see also* COLO. REV. STAT. ANN. § 18-3-104(1)(a) (West 1990 & Supp. 1996) (pronouncing that "[a] person commits the crime of manslaughter if... [s]uch person recklessly causes the death of another person."); *id.* § 18-1-501(8) (ruling that "[a] person acts recklessly when he consciously disregards a substantial and unjustifiable risk that a result will occur or that a circumstance exists."); Sue Lindsay, *Jurors Will Hear How Doctor Fell Asleep During 4 Surgeries*, ROCKY MTN. POST, May 17, 1996, at 20A, *available in* 1996 WL 7569166 [hereinafter Lindsay I] (explaining that a conviction would require the prosecutor to prove that Dr. Verbrugge "consciously disregarded a substantial risk or verifiable risk" that the youth would die as a result of the doctor's behavior).

Dr. Verbrugge's attorney maintained that the death was caused by malignant hyperthermia (MH), a rare genetic reaction to the anesthetic drugs. *See* Howard Pankratz, *Doctor Faults Verbrugge in Death; Earlier Testimony That Anesthesiologist Fell Asleep During Boy's Surgery Backed*, DENV. POST, Sept. 16, 1995, at B3, *available in* 1995 WL 10197432 [hereinafter Pankratz I]. According to the prosecution, however, many children show signs similar to the symptoms of MH when first placed under anesthesia; therefore, an anesthesiologist should be on the alert when treating pediatric patients. *See id.* The prosecution claimed that the boy's death was the result of a combination of a "clogged airway and overheating that caused carbon dioxide to build up to toxic levels." Bensel & Goldberg, *supra* note 3, at B10. Furthermore, although maintaining that the cause of death was not MH, the prosecutor argued that an MH death was preventable because a special anesthesia machine and an antidote for MH were both available at the hospital. *See* Pankratz I, *supra*, at B3.

An investigation into the incident revealed that Dr. Verbrugge failed to react to complications during a routine ear surgery because the doctor fell asleep for short intervals during the three-hour operation. *See* Howard Pankratz, *Witness: Verbrugge Said He Corrected "Nodding Off,"* DENV. POST, Oct. 5, 1996, at B3, *available in* 1996 WL 12633156 [hereinafter Pankratz II]. Further, investigation revealed that Dr. Verbrugge had fallen asleep during several other operations prior to the fatal incident. *See id.*; *see also* Sara Lewis, *Doctor Dozed in Other Operations, Nurses Testify*, DENV. POST, Apr. 25, 1996, at B6, *available in* 1996 WL 6691528 (reporting that one nurse spoke with Dr. Verbrugge concerning his falling asleep and another nurse wrote reports about the incidents); *Physician on Trial in Boy's Death; Colorado Alleges Anesthesiologist Had History of Dozing Off*, CHI. TRIB., Oct. 13, 1996, at 8, *available in* 1996 WL 2716908 (noting that a colleague thought that Dr. Verbrugge had a drug problem and another colleague suggested techniques to Dr. Verbrugge for staying awake and alert during surgery). Unfortunately, because the hospital had only reprimanded the doctor on those occasions, as opposed to suspending his privileges for over 30 days, the prior incidents were not reportable to the Colorado State Medical Board

boy who died during a routine ear operation summed up the current state of affairs concerning the public's inability to acquire pertinent information about medical professionals: "I can find out more about my plumber than I can about my doctor."[130] Recognizing the

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and hence were not reportable to the NPDB. *See* Sue Lindsay, *Doctor Was Warned About Sleeping, Court Told*, ROCKY MTN. NEWS, Oct. 5, 1996, at 26A, *available in* 1996 WL 12349556 [hereinafter Lindsay II] (stating that six months before the child's death, medical officers at the hospital had warned Dr. Verbrugge about his propensity for falling asleep during surgery). An administrator for the state medical board explained that having privileges suspended for even one day are reportable to the state board, but admitted that physicians typically resign to prevent such reporting. *See* Schrader, *supra* note 127, at A1. Dr. Verbrugge's prior incidents were discovered by the medical board only after the doctor was charged with manslaughter and a formal request was made for his peer review file. *See* Bensel & Goldberg, *supra* note 3, at B10.

A jury found Dr. Verbrugge guilty of grossly negligent medical care because his conduct represented "an extreme deviation from generally accepted standards of medical care." Howard Pankratz, *Verbrugge to Face Trial Again; Date Set for Manslaughter Case*, DENV. POST, Nov. 13, 1996, at B1, *available in* 1996 WL 12636564 [hereinafter Pankratz III]. Grossly negligent medical care is a misdemeanor that carries a $1000 fine and a maximum prison term of up to 12 months. *See id.* As to the manslaughter charge, a deadlocked jury forced a retrial. *See* Sue Lindsay, *Doctor Faces Second Trial in Boy's Death; First Jury Was Split on Felony Charge Against Anesthesiologist*, ROCKY MTN. NEWS, Nov. 13, 1996, at 4A, *available in* 1996 WL 12356143 [hereinafter Lindsay III]; Pankratz III, *supra*, at B1 (explaining that the jury split ten-to-two in favor of convicting Dr. Verbrugge of manslaughter but that the two jurors who voted for not guilty thought the cause of death was MH). District Judge Dick Spriggs rejected the defense's argument that a retrial on the manslaughter charge would amount to double jeopardy. *See id.*

The Colorado Board of Medical Examiners revoked Dr. Verbrugge's license after an administrative law judge determined that the doctor was grossly negligent for failing to monitor the condition of his patient. *See* Bensel & Goldberg, *supra* note 3, at B10. Specifically, Dr. Verbrugge was grossly negligent for "failing to calibrate the anesthesia machine, failing to monitor the patient during surgery, failing to respond to evidence of a developing crisis and failing to remain awake and otherwise alert and vigilant." *Id.* Nevertheless, in November 1995, it was reported that the State of California granted Dr. Verbrugge a five-year probationary medical license on the condition that Dr. Verbrugge would submit to a psychiatric evaluation and to supervision by another physician. *See Accused Doctor Gets Calif. OK*, DENV. POST, Nov. 1, 1995, at B5, *available in* 1995 WL 10201248 [hereinafter *Accused Doctor*]. The family of Richard Leonard, the young victim, brought a civil suit against Dr. Verbrugge, but the case settled for an undisclosed amount. *See* Sue Lindsay, *Doctor Denies Mistreatment of Patient*, ROCKY MTN. NEWS, Apr. 27, 1996, at 17A, *available in* 1996 WL 7566848 [hereinafter Lindsay IV].

[130] Schrader, *supra* note 127, at A1. United States Representative Ron Wyden (D-Or.), the main sponsor of HCQIA, adequately expressed the frustration many consumers feel when trying to obtain information regarding their physicians when he stated: "Unfortunately, Americans today have more product performance information available to them when purchasing breakfast cereal then when choosing a heart surgeon." Robin E. Margolis, *Should Patients Have Access to National Physicians Malpractice Records?*, 10 HEALTHSPAN 24, 24 (1993); *see also* Adler, *supra* note 7, at 737 n.246 (noting that consumers cannot obtain information concerning their physi-

limitation of the NPDB, consumer advocacy groups such as the Public Citizen Health Research Group (Public Citizens)[151] and the National Center for Patient's Rights (NCPR)[152] have encouraged the federal government to open the NPDB to the general public.[153] The health care profession disapproves of opening the NPDB[154] because of the fear that consumers will be misled by the information contained therein.[155]

In sum, although they provide one mechanism to assure minimum professional competence, peer review actions do not adequately protect consumers from incompetent physicians.[156] The self-regulating structure of peer review actions often fails to hold physicians accountable for incompetent care because physicians are uncomfortable disciplining their colleagues.[157] Finally, even when peer review does result in disciplinary actions, consumers do not have access to this information and must continue to rely on onerous and inadequate methods of acquiring information about their physicians.[158]

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cians but can currently obtain information from the National Highway Traffic Safety Administration regarding the number of complaints lodged against their automobiles and from the Better Business Bureau regarding local businesses).

[151] Public Citizens is a non-profit organization for consumers. *See* Glazer, *supra* note 86, at Z10.

[152] The NCPR is an advocacy group for patient's rights and malpractice victims. *See id.*

[153] *See* Margolis, *supra* note 130, at 24 (reporting that representatives from Public Citizens and the NCPR testified at a hearing of the House of Representatives's Small Business Committee's Regulation Subcommittee about the public's need for easily accessible information regarding physicians).

[154] *See id.* (noting that the AMA voted to abolish the NPDB).

[155] *See id.* at 25 (reporting that United States Representative Larry Combest (R-Tex.), a prominent supporter of the HCQIA, noted that although medical malpractice settlements are required to be reported, the mere fact that a physician settled a malpractice case does not necessarily signify that the physician was negligent). Further, Representative Combest also expressed concern that publicizing this information would hinder efforts aimed at promoting physician cooperation. *See id.*

[156] *See supra* notes 95-99; *see also* Adler, *supra* note 7, at 696-700 (delineating pre-HCQIA deficiencies in the peer review process); Zeve, *supra* note 123, at 26-27 (outlining post-HCQIA deficiencies).

[157] *See* Adler, *supra* note 7, at 697.

[158] *See supra* note 86 and accompanying text (discussing the problems of obtaining information from state licensing boards). A medical board investigator recommended that ambitious and energetic consumers consult the civil index at their local courthouse because records of final judgments and pending lawsuits are public. *See* Glazer, *supra* 86, at Z10.

## III. CRIMINAL SANCTIONS AS AN ADDITIONAL MECHANISM TO MONITOR COMPETENCE

### *A. Introduction*

Sanctions[139] provide society with a mechanism to encourage quality health care. Health care professionals who fail to comply with the appropriate standard of care can be excluded from the profession through sanctions.[140] While the traditional civil sanctions, which consist of lawsuits and disciplinary actions, aid in monitoring incompetent physicians,[141] their overall effectiveness in excluding incompetent physicians from the medical profession is lacking.[142] Traditional civil sanctions seek to correct and improve the performance of physicians rather than exclude physicians from the profession.[143] As such, severe deterrent sanctions may be necessary to protect consumers when the corrective civil sanctions fail to exclude incompetent physicians whose deficiencies result in fatal medical errors.[144]

The use of criminal sanctions to punish physicians for negligence is not a new phenomenon.[145] Although research has not re-

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[139] Sanction is defined as a "[p]enalty or other mechanism of enforcement used to provide incentives for obedience with the law or with rules and regulations." BLACK'S LAW DICTIONARY 1341 (6th ed. 1990).

[140] *See* Jost, *supra* note 14, at 850.

[141] *See supra* notes 39-45, 64-69, 90-94, 101-22 and accompanying text (discussing how medical malpractice suits and professional disciplinary actions attempt to assure quality health care).

[142] *See supra* notes 53-63, 70-89, 95-99, 123-38 and accompanying text (explaining that medical malpractice suits and professional disciplinary actions inadequately promote quality health care).

[143] *See* Jost, supra note 14, at 850 (noting that corrective sanctions can be effective when the physician has the capacity to provide competent medical care, but merely lacks proper guidance).

[144] *See id.* (explaining that deterrent sanctions "may be appropriate for normative deficiencies that result in technical or judgment errors or for careless production processes"); *see also* Oberman, *supra* note 17, at 2 (noting that critics of peer review and licensing boards argue that the disciplinary systems are "slow-moving," and resolving that "[s]ending a doctor to jail may be the only way to get him out of practice").

[145] *See, e.g.*, Donald C. Barrett, *Homicide Predicated on Improper Treatment of Disease or Injury*, 45 A.L.R. 3d 114, 123 (1972) (citing State v. Hardister, 38 Ark. 605, 609-10, 613-14 (1882) (holding that an indictment charging obstetrician with malpractice, abandonment, and practicing without due caution was sufficient to sustain a manslaughter charge); People v. Long, 103 P.2d 969, 977 (Cal. 1940) (holding that the evidence was sufficient to sustain a manslaughter conviction against physician who performed an abortion without due caution and circumspection); State v. Lester, 149 N.W. 297, 299 (Minn. 1914) (upholding manslaughter indictment of physician charged with negligently operating an x-ray machine that fatally wounded a patient)).

vealed any statistical evidence documenting the number of physicians subjected to criminal sanctions for the provision of incompetent care, anecdotal stories and newspaper headlines suggest that this practice is on the rise.[146] In the cases of Dr. Klvana,[147] Dr. Verbrugge,[148] and Dr. Benjamin,[149] criminal sanctions were used when the self-policing system failed to correct or exclude the incompetent physicians from the medical profession. In other cases, however, prosecutors have criminally charged physicians even when there was no opportunity for the self-policing system to address, much less correct, the incompetent conduct.[150]

Determining where the line is drawn between criminal medical errors, which warrant deterrent sanctions, and clinical medical errors, which warrant only corrective sanctions, requires examining the actor's state of mind.[151] While the legal issue concerns where this line is drawn, this Note addresses the broader policy issue of whether the use of criminal sanctions resolves the short-comings of the civil sanctions currently used to monitor the quality of health care. The following section focuses on the legal issue—that level of incompetence sufficient to justify pursuing criminal charges against a physician for a clinical error.

### *B. Criminal Liability*

Unlike civil liability, which is not concerned with the moral culpability of the wrongdoer,[152] criminal law is premised on the notion that conviction for a crime requires a guilty mind, mens rea.[153] As

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[146] *See, e.g.*, Maier, *supra* note 4, at A35 (reporting that more and more prosecutors in the United States are indicting health care professionals for fatal medical errors); Smith, *supra* note 4, at 131 (noting "a marked growth in the number of prosecutions" against physicians whose negligence resulted in patients' deaths); *see also supra* note 4 and accompanying text (discussing medical community's concern over the increased number of criminal prosecutions).

[147] *See supra* note 88 (discussing the case of Dr. Klvana, who incompetently administered a labor-inducing drug).

[148] *See supra* note 129 (detailing the case of Dr. Verbrugge, who fell asleep during an operation).

[149] *See infra* notes 217-25 and accompanying text (explaining the case of Dr. Benjamin who botched an abortion).

[150] *See infra* notes 177-98 and accompanying text (discussing the case of Dr. Einaugler); *infra* notes 199-216 and accompanying text (discussing the case of Dr. Swords).

[151] *See* Smith, *supra* note 4, at 137.

[152] An exception to this maxim is punitive damages. *See supra* note 45 and accompanying text (discussing punitive damages).

[153] *See* Smith, *supra* note 4, at 133, 137; *see also* Kenneth W. Simons, *Culpability and Retributive Theory: The Problem of Criminal Negligence*, 5 J. CONTEMP. LEGAL ISSUES

discussed previously, negligent conduct is conduct that fails to meet an objective standard of reasonable care,[154] thereby creating an unjustified risk that the conduct will result in harm.[155] Negligent medical conduct is conduct by a physician that does not comport with the ordinary degree of knowledge and skill commonly possessed by physicians in the same field of practice.[156] The successful prosecution of a physician for incompetence, however, requires a degree of negligence beyond mere civil negligence.[157]

The major distinction between risk-taking sufficient to create criminal liability, as opposed to civil liability, is the level of indifference to the attendant risk of harm.[158] If the degree of indifference to the risk of harm amounts to either criminal negligence or recklessness, prosecution of the physician may be appropriate.[159] Criminal

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365, 375 (1994) (explaining that for negligent conduct "the actor's mental states (including his beliefs and desires) are incidental or irrelevant").

[154] *See supra* notes 39-40 and accompanying text. The concept of negligence measures one's conduct against an objective standard of how a reasonable person should act to avoid adverse consequences. *See* Smith, *supra* note 4, at 134-35.

[155] *See* DRESSLER, *supra* note 10, at 112 (explaining that "[a] person's conduct is 'negligent' if it constitutes a deviation from the standard of care that a reasonable person would have observed in the actor's situation. Conduct constitutes such a deviation if the actor takes an unjustifiable risk of causing harm to another.").

[156] *See supra* notes 41-42 and accompanying text (outlining the standard of care in medical malpractice actions); *see also* Smith, *supra* note 4, at 135 (arguing that, although medical care that falls below acceptable standards may constitute negligence, such care may not support a finding of criminal culpability).

[157] *See* DRESSLER, *supra* note 10, at 113 (explaining that "the level of negligence should be so great 'that it would be shocking to allow the actor's lack of awareness to excuse his actions in the circumstances'"); Smith, *supra* note 4, at 138-42 (explaining that the concept of gross negligence was developed to distinguish between those whose conduct was deserving of criminal punishment and those whose conduct, while failing to meet the appropriate standard of care, did not deserve to be punished in this manner). The concept of differing degrees of negligence, first developed under Roman Law, was later adopted by English common law. *See* PROSSER ET AL., *supra* note 36, at 197. Three levels of negligence developed, including: "[(1)] 'slight' negligence, defined as a failure to use great care; [(2)] ordinary negligence, or failure to use reasonable care; and [(3)] 'gross' negligence, which is failure to exercise even slight care." *Id.* Explained differently, the distinction between the concepts of "negligence, gross negligence and recklessness [is] the distinctions among a fool, a damned fool, and a God-damned fool." *Id.* at 198 (quoting Judge Magruder, HARVARD LAW RECORD, Apr. 16, 1959).

[158] *See* DRESSLER, *supra* note 10, at 113. Whether an act is criminally or civilly negligent depends on the degree to which the actor's risk-taking is objectively unjustifiable—if the risk is substantial, the actor is criminally negligent. *See id.* In other words, when the gravity of an injury and the probability that such an injury will occur drastically outweigh the burden to the actor in refraining from the risky conduct, criminal liability can be established. *See id.* at 112-13.

[159] *See, e.g.*, Bensel & Goldberg, *supra* note 3, at B10 (discussing the cases of Dr. Einaugler, Dr. Verbrugge, and Dr. Benjamin). Although often used interchangea-

negligence is conduct that falls below the acceptable standard of care and creates a substantial and unjustifiable risk of harm.[160] The risk-taking is objective because it is sufficient to find that, as a reasonable person,[161] the actor should have been aware of the risk.[162] In the context of medical conduct, when a physician's negligence rises to the level of gross inattention, gross lack of competency, or criminal indifference to the patient's well-being, criminal negligence can be established.[163] Where, however, the patient's death results from an inadvertent mistake or an error in judgment, and the physician did

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bly, criminal negligence and recklessness are two different concepts of culpability; recklessness is the more morally culpable version of criminal risk taking. *See* DRESSLER, *supra* note 10, at 112, 115; Smith, *supra* note 4, at 140. The judicial system, however, as evidenced by courts' interchangeable treatment of criminal negligence and recklessness, appears not to be as concerned with the moral justification for punishing negligence as is academia. *See* DRESSLER, *supra* note 10, at 113; Smith, *supra* note 4, at 132.

[160] *See* DRESSLER, *supra* note 10, at 113 (defining criminal negligence as "conduct that represents a gross deviation from the standard of reasonable care, i.e., a person is criminally negligent if he takes a *substantial* and unjustifiable risk of causing harm that constitutes the offense charged"). English common law adopted the concept of criminal negligence to distinguish negligent conduct that was criminally punishable from negligent conduct that, although it failed to meet an objective standard of care, gave rise only to a claim for damages. *See* Smith, *supra* note 4, at 138; *see also* GEORGE P. FLETCHER, RETHINKING CRIMINAL LAW 262-63 (1978) (noting that the American criminal law system has traditionally distinguished negligence sufficient for civil liability from negligence sufficient for criminal liability by demanding "gross negligence" in the criminal context); Simons, *supra* note 153, at 374 n.24 (explaining that "'[t]he risk must be of such a nature and degree that the actor's failure to perceive it . . . involves a gross deviation from the standard of care of a reasonable person'") (citation omitted).

[161] While criminal jurists have struggled to define the "reasonable person," a leading tort treatise states that "'[the reasonable person] is not to be identified with any ordinary individual, who might occasionally do unreasonable things; [the reasonable person] is a prudent and careful person, *who is always up to standard.*'" DRESSLER, *supra* note 10, at 115 (citing DOBBS ET AL., *supra* note 37, § 32, at 175). Although subject to increasing criticism, the current trend in the law is to incorporate "unusual *physical* characteristics (e.g., blindness)" into the reasonable person standard when it is relevant to the case; however, "unusual *mental* characteristics" are *not* incorporated. *See id.* (emphases added).

[162] *See id.* at 112, 116; *see also* Simons, *supra* note 153, at 372 (explaining that one function of the negligence concept in criminal law is to specify objective criterion for a reasonable person standard capable of application in many different contexts).

[163] *See* FLETCHER, *supra* note 160, at 263; *see also* Gian-Cursio v. State, 180 So. 2d 396, 396-97, 399 (Fla. Dist. Ct. App. 1965) (upholding conviction for manslaughter of two chiropractic physicians who treated patients' tuberculosis without medication) (citing Hampton v. State, 39 So. 421, 423, 424 (Fla. 1905) (confirming a manslaughter conviction of a physician who inflicted mortal wounds to his patient's womb, abdomen, and internal organs)). Criminal negligence may exist, for example, where a physician is grossly ignorant of the effects of remedies utilized, lacks proper skill to perform a procedure or use an instrument, or fails to provide a patient with sufficient instructions concerning the use of medication. *See id.* at 399.

nothing that a skilled physician in the same situation might not have done, criminal liability should not attach.[164]

Recklessness, on the other hand, signifies a more culpable degree of risk-taking.[165] In contrast to criminal negligence in which the actor is unaware of the substantial and unjustified risk, recklessness involves a situation in which the actor is aware of the risk but makes an affirmative decision to ignore the risk and continues acting in a dangerous manner.[166] Therefore, unlike criminal negligence, recklessness is based on subjective fault where the actor is aware of a substantial and unjustified risk inherent in the conduct, but proceeds in the face of such risk.[167] The actor is culpable precisely because she places her own objectives above and beyond the safety of others.[168]

At common law there were three levels of risk-taking for homicide:[169] (1) risk-taking that rose to the level of murder; (2) risk-taking that rose to the level of manslaughter; and (3) risk-taking that rose only to the level of civil liability.[170] Generally speaking, manslaughter

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[164] *See Gian-Cursio*, 180 So. 2d at 399; *see also* Smith, *supra* note 4, at 146 (explaining that the criminal law should not apply to situations in which "a minor assault resulted in freak damage").

[165] *See* DRESSLER, *supra* note 10, at 115.

[166] *See id.* at 116.

[167] *See id.* (explaining that "recklessness implicates *subjective* fault, in that the actor was aware of the substantial and unjustifiable risk he was taking, and yet he consciously disregarded it and proceeded with his dangerous conduct"); Simons, *supra* note 153, at 374 n.25 (stating that "'[t]he risk must be of such a nature and degree that . . . its disregard involves a gross deviation from the standard of care [of] a law-abiding person.'") (quoting MODEL PENAL CODE § 2.02(2)(c) (1985)). One criminal law scholar observed that a reasonable person standard shifts to "a law-abiding person" standard when defining recklessness because the culpability for recklessness consists of conscious risk-taking that departs from a legally permissible level of risk-taking. *See* FLETCHER, *supra* note 160, at 262. In direct contrast, culpability for negligence consists of failing to meet a standard of attentiveness deemed reasonable. *See id.* Note, however, that the distinction between subjective fault and objective fault required to prove recklessness or criminal negligence, respectively, is relevant only to the extent that the two terms are differentiated. *See* DRESSLER, *supra* note 10, at 115-16.

[168] *See* Smith, *supra* note 4, at 137. Malice is a term that connotes that an actor committed a social harm with the intent to commit that harm. *See* DRESSLER, *supra* note 10, at 116.

[169] Homicide is defined as the "killing of a human being by a human being." DRESSLER, *supra* note 10, at 463 (citation omitted).

[170] *See* KAPLAN & WEISBERG, *supra* note 5, at 195. The requisite level of risk-taking sufficient to satisfy the different categories at common law was imprecise and unclear. *See* DRESSLER, *supra* note 10, at 478; *see also* KAPLAN & WEISBERG, *supra* note 5, at 195 (quotation omitted). Common-law murder is defined as "'the killing of a human being by another human being with malice aforethought.'" DRESSLER, *supra* note 10, at 467. Common-law manslaughter is defined as "'an unlawful killing of a human being by another human being *without* malice afterthought.'" *Id.* (opining

involves a criminally negligent killing while murder requires an extremely reckless homicide.[171] In the context of medical errors, the crimes charged against health care professionals are typically manslaughter[172] or negligent homicide.[173] When malice motivates the excessive risk-taking, the crime may be elevated to the level of murder.[174] Additional charges have also been used by prosecutors,

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that the term criminal negligence is the most appropriate modern term for manslaughter).

Many jurisdictions, following the common-law approach, include both recklessness and criminal negligence as the mens rea for the crime of involuntary manslaughter. *See* KAPLAN & WEISBERG, *supra* note 5, at 196-97; *see also* FLETCHER, *supra* note 160, at 262 & n.7 (maintaining that the term involuntary manslaughter is merely an antiquated way of referring to "unintentional homicide"). In those states, it is inconsequential whether the actor consciously disregarded a substantial and unjustified risk or acted inadvertently, so long as the conduct involved more than the mere negligence sufficient for civil liability. *See* KAPLAN & WEISBERG, *supra* note 5, at 196. Other jurisdictions, however, require a degree of recklessness for involuntary manslaughter, making proof of gross negligence insufficient to support a conviction. *See id.* at 197. In states that distinguish between recklessness and criminal negligence, the latter suffices to prove negligent homicide. *See* FLETCHER, *supra* note 160, at 264; *see also* ALA. CODE § 13A-6-4(a) (1994) (explaining that "[a] person commits the crime of criminally negligent homicide if he causes the death of another person by criminal negligence"); *id.* § 13A-6-3(a) (pronouncing that "[a] person commits the crime of manslaughter if: (1) He recklessly causes the death of another person."); ARIZ. REV. STAT. § 13-1102(A) (1989) (noting that "[a] person commits negligent homicide if with criminal negligence such person causes the death of another person"); *id.* § 13-1103(A) (noting that "[a] person commits manslaughter by: (1) recklessly causing the death of another person"); COLO. REV. STAT. § 18-3-105 (1990) (pointing out that "[a]ny person who causes the death of another person by conduct amounting to criminal negligence commits criminally negligent homicide which is a class [five] felony"); *id.* § 18-3-104(1) (stressing that "[a] person commits the crime of manslaughter if: (a) Such person recklessly causes the death of another person.").

[171] *See* DRESSLER, *supra* note 10, at 478.

[172] *See* Barrett, *supra* note 145, at 121. The Model Penal Code codifies the common-law crimes of murder and manslaughter and also recognizes the crime of negligent homicide, which the common law did not recognize. *See* DRESSLER, *supra* note 10, at 500.

[173] *See* Barrett, *supra* note 145, at 122. Negligent homicide, which is codified in the Model Penal Code at section 210.4, is the equivalent of involuntary manslaughter at common law. *See* DRESSLER, *supra* note 10, at 505. Liability for negligent killing expanded during the 1920s and 1930s with the advent of new offenses, including negligent homicide connected with driving a motor vehicle. *See* FLETCHER, *supra* note 160, at 264.

[174] *See* FLETCHER, *supra* note 160, at 264-65 (noting that one approach is to find that the defendant was motivated by "'an abandoned or malignant heart,'" as required by California Penal Code section 188). One criminal law scholar notes, however, that although these words appear in the statute, California courts typically instruct juries to determine whether the defendant, "'for a base, anti-social motive and with wanton disregard of human life'[,] did an act 'that involved a high degree of probability that it would result in death.'" *Id.* at 265 (citation omitted).

including the crimes of reckless endangerment[175] and willful violation of a public health law.[176] In sum, the level of wrongful risk-taking that a physician engages in will determine whether the physician should be charged criminally, and if so, the degree of criminal liability. The following subsection provides examples of physicians who have been criminally charged with either reckless endangerment, manslaughter, or murder for their patients' deaths.

### C. *Examples of Criminal Prosecutions*

#### 1. Dr. Einaugler

In *People v. Einaugler*,[177] Dr. Gerald Einaugler, an attending physician at a nursing home,[178] was sentenced to fifty-two weekends[179] in prison for reckless endangerment and willful violation of the state health code for delaying the transfer of a nursing home resident to a

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[175] *See* People v. Einaugler, 618 N.Y.S.2d 414, 415 (App. Div. 1994) (*Einaugler I*) (citing N.Y. PENAL LAW § 120.20 (McKinney 1990) (explaining that "[a] person is guilty of reckless endangerment . . . when he recklessly engages in conduct which creates a substantial risk of serious physical injury to another person."), *appeal denied*, 627 N.Y.S.2d 331 (N.Y. 1995), *habeas corpus denied in part and dismissed in part*, Einaugler v. Supreme Ct. of N.Y., 918 F. Supp. 619 (E.D.N.Y. 1996) (*Einaugler II*), *aff'd*, 109 F.3d 836 (2d Cir. 1997) (*Einaugler III*). A federal district court, addressing Dr. Einaugler's habeus petition, observed:

> Reckless endangerment is the lowest of three levels of crimes prohibiting reckless conduct. The statutes defining it seek to prevent the risk created by the actor's conduct, not a particular outcome. Thus unlike reckless conduct which produces death (depraved mind murder; manslaughter) or physical injury (assault), no injury results from reckless endangerment. *The risk of injury alone sustains prosecution.*

*Einaugler II*, 918 F. Supp. at 626-27 (quotation omitted).

[176] *See Einaugler I*, 618 N.Y.S.2d at 415 (citing N.Y. PUBLIC HEALTH LAW § 12-b[2] (McKinney 1990)). The *Einaugler* court explained that the New York Public Health Law "prohibits the commission of 'an act of . . . neglect.'" *Id.* Further, as the court explained, the term neglect is defined as

> failure to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility while such patient or resident is under the supervision of the facility, including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living.

*Id.*

[177] *Einaugler I*, 618 N.Y.S.2d 414.

[178] *See Einaugler III*, 109 F.3d at 838.

[179] According to one report, Dr. Einaugler arrived at the prison at 9:00 a.m. on Saturday morning and was released Sunday evening, repeating the process every weekend for 52 weekends. *See* Larry McShane, *Doctor Jailed After Woman Dies in Medical Misstep*, BUFF. NEWS, May 18, 1997, at A14, *available in* 1997 WL 6436672.

hospital.[180] The medical mistake for which Dr. Einaugler was convicted began when Dr. Einaugler ordered a feeding solution to be administered into the patient's abdomen catheter, which Dr. Einaugler thought was a gastrointestinal feeding tube, but was, in fact, a peritoneal dialysis catheter.[181] Thus, a liquid feeding solution filled the patient's peritoneal space instead of the special fluid that was supposed to extract waste product from the patient's blood.[182] Several feedings were administered to the patient before a nurse detected the error and notified her supervisor who, in turn, notified Dr. Einaugler.[183] After learning about the error, Dr. Einaugler contacted Dr. Dunn, the Chief of Nephrology,[184] at the hospital where the catheter was inserted.[185] According to Dr. Dunn, he instructed Dr. Einaugler to transfer the patient immediately.[186] Dr. Einaugler waited over ten hours from the time of his discussion with Dr. Dunn before authorizing the transfer of the patient to the hospital where she eventually died a few days later.[187] Despite conflicting testimony

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[180] *See id.* Ms. Alida Lamour suffered from end-stage renal disease, which is a disease that leads to permanent kidney failure requiring dialysis in order to perform artificially the function of the kidneys. *See Einaugler II*, 918 F. Supp. at 621. Ms. Lamour had been receiving hemodialysis treatment (a process by which products from the blood are filtered through a machine) at Interfaith Hospital; however, her weak cardiovascular system could no longer tolerate hemodialysis and she was switched to peritoneal dialysis. *See id.* Peritoneal dialysis involves placing a thin catheter permanently inside the cavity of the patient's abdomen, the peritoneal space. *See id.* A special fluid is then administered through the catheter that fills the peritoneal space and extracts waste products from the many blood vessels that line the wall of the patient's abdomen. *See id.* After the hospital inserted the catheter for the peritoneal dialysis, Ms. Lamour was transferred back to the nursing home. *See id.*

[181] *See Einaugler* II, 918 F. Supp. at 621-22.

[182] *See id.* at 621; *see also supra* note 180 (explaining the term "peritoneal dialysis"). Unfortunately, the nursing home was not capable of handling Ms. Lamour's medical care because the medical staff was not familiar with the peritoneal dialysis catheter and there was no protocol for the care of a patient with such a catheter. *See Einaugler II*, 918 F. Supp. at 621. Dr. Einaugler testified that he read the patient's transfer form that indicated that she had a Tenchkoff catheter, but because the form said that the catheter was inserted for "intermittent peritoneal dialysis," he believed that the patient was receiving intermittent dialysis treatment, which requires that a new catheter be inserted for every treatment. *See id.* at 622.

[183] *See Einaugler II*, 918 F. Supp. at 622. By rolling the patient back and forth, the nurse was able to drain some of the feeding product from the catheter. *See id.*

[184] A nephrologist is a kidney specialist. *See* People v. Einaugler, 618 N.Y.S.2d 414, 415 (App. Div. 1994) (*Einaugler I*).

[185] *See Einaugler II*, 918 F. Supp. at 622.

[186] *See id.* at 623.

[187] *See id.* at 624-25. In summarizing the facts of the case, the district court pointed out that there was evidence to suggest that critical medical treatment may not have been administered to Ms. Lamour until the day after her arrival at the

concerning the doctors' conversation,[188] the jury ultimately determined that Dr. Einaugler was guilty of reckless endangerment and willful violation of a public heath law.[189]

A central issue in the *Einaugler* case was the concept of risk-taking.[190] The appellate court concluded that the evidence supported the finding that Dr. Einaugler consciously appreciated, but chose to disregard "a substantial risk of serious physical injury to the

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hospital. *See id.* at 623. The district court admitted that, during the course of Ms. Lamour's treatment, several acts of malpractice were committed by many actors. *See id.* at 624. For example: (1) the patient was transferred to an institution that did not have adequate training to care for her, (2) a feeding solution was inadvertently fed into a dialysis catheter, (3) the error was not detected for over a day, (4) a decision was made to delay transferring the patient to a hospital, and (5) once at the hospital, the necessary medical treatment might have been improperly delayed. *See id.*

[188] *See id.* at 622-23. Dr. Einaugler testified that he told Dr. Dunn on Sunday morning that, although he had inadvertently ordered a feeding solution to be administered through the catheter, most of the solution had been drained and the nurses assured him that the patient was stable. *See id.* at 622. According to Dr. Einaugler, Dr. Dunn told him, "'[D]on't get panicky. Don't worry, it doesn't seem like any emergency the way you are describing it to me. If she's stable, send her to the hospital Monday, and then we can evaluate her for dialysis and lavage.'" *Id.* Dr. Einaugler testified that after the conversation he went to the nursing home to examine the patient and found her to be in stable condition. *See id.* Dr. Dunn, however, maintained that, upon learning about the situation from Dr. Einaugler, he remarked, "'[W]ell let's get the patient into the hospital.'" *Id.* at 623. According to Dr. Dunn, Dr. Einaugler assured him that the patient would be transferred. *See id.* In addition, there was conflicting testimony concerning a conversation between Dr. Einaugler and Dr. Khaski, the nursing home's supervising physician. *See id.* Although Dr. Khaski confirmed Dr. Einaugler's testimony regarding the conversation with Dr. Dunn, Dr. Khaski testified that he advised Dr. Einaugler to transfer the patient immediately. *See id.* On this issue, Dr. Khaski's testimony was in direct contrast to that of Dr. Einaugler. *See id.*

[189] *See id.* at 624, 626. The New York Supreme Court, Appellate Division, held that the evidence produced at trial was legally sufficient to determine that Dr. Einaugler recklessly endangered the life of his patient and willfully violated a public health statute. *See Einaugler I*, 618 N.Y.S.2d at 415. Dr. Einaugler petitioned the Eastern District of New York for a writ of habeas corpus claiming that there was insufficient evidence to warrant his conviction on the two counts. *See Einaugler II*, 918 F. Supp. at 624. In addition, Dr. Einaugler argued that the prosecution's evidence, which established that the cause of death was from chemical peritonitis, denied him a fair trial because he was on trial for reckless endangerment, not homicide. *See id.* The district court held that the evidence was sufficient to confirm the conviction, and the admission of evidence regarding the cause of death did not prejudice Dr. Einaugler because "[t]he essence of the charge alleged . . . was the substantial risk of death created by [Dr. Einaugler's] delay in hospitalizing Ms. Lamour." *Id.* at 633. The United States Court of Appeals for the Second Circuit affirmed the district court's decision. *See* People v. Einaugler, 109 F.3d 836, 843 (2d Cir. 1997) (*Einaugler III*).

[190] *See Einaugler II*, 918 F. Supp. at 630 (stressing that "[t]he issue was the *risk* to [Ms. Lamour] created by petitioner's failure to hospitalize her for ten hours").

patient."[191] The court further added that Dr. Einaugler's actions amounted to a "gross deviation from the standard of conduct" that a reasonable person in a similar situation would have observed.[192] Moreover, because the conviction required more than a mere showing of negligence, the court flatly rejected Dr. Einaugler's argument that affirming the conviction would result in the criminal prosecution of medical professionals for "honest errors in medical judgment."[193]

In denying Dr. Einaugler's petition for a writ of habeas corpus, a federal district court stressed that Dr. Einaugler was not being held criminally liable for the careless error of ordering the feeding solution.[194] Such an error was the result of ignorance, which, the district court explained, in and of itself is insufficient to prove the element of criminal intent.[195] Dr. Einaugler's conscious deviation from the appropriate standard of care provided the key element for a finding of criminal liability.[196] Of import to this Note, the district court cautioned that the conviction did not signal a precedent for holding physicians criminally liable for faulty medical judgments.[197] According to the court, the case was not about Dr. Einaugler's exercise of medical judgment; rather, it was about whether Dr. Einaugler chose to ignore the judgment of a doctor whom he believed to be more qualified, thereby subjecting the patient to a substantial and unjustifiable risk.[198]

2. Dr. Swords

In another highly publicized case,[199] Dr. Jack Swords was indicted on a manslaughter charge in connection with a patient's

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[191] *Einaugler I*, 618 N.Y.S.2d at 415.

[192] *Id.*

[193] *Id.* at 416.

[194] *See Einaugler II*, 918 F. Supp. at 625. See *supra* note 189 for a discussion of the grounds for Dr. Einaugler's petition for writ of habeas corpus.

[195] *See Einaugler II*, 918 F. Supp. at 625.

[196] *See id.* at 625, 631.

[197] *See id.* at 635.

[198] *See id.* Dr. Einaugler began serving his sentence of 52 weekends in prison at Rikers Island on May 17, 1997. *See* McShane, *supra* note 179, at A14. Dr. Einaugler continues to insist that his error was not criminal: "'I have retried this case in my mind so many times and still, I don't see where I did anything wrong . . . . I admitted from day one that I made a mistake with the (feeding) tube. But not after. No.'" *Id.*

[199] There is no reported court case for Dr. Swords because the prosecution dropped the charges. *See* Oberman, *supra* note 17, at 2. As explained earlier, however, the term "case" in this Note encompasses situations in which physicians have

death resulting from the doctor's failure properly to monitor the patient's diabetes.[200] In December 1989, the patient was diagnosed as hypoglycemic and taken off insulin at the hospital where he was being treated for pneumonia.[201] Thereafter, the diabetes was regulated through diet and oral medication.[202] Approximately one month after returning to the nursing home,[203] the patient was re-hospitalized for pneumonia and had a highly elevated blood sugar level.[204] Although the hospital stabilized the diabetes, the patient never awoke from a coma and died two weeks later.[205]

A physician for the state determined that the patient's diabetes was improperly monitored at the nursing home resulting in the coma that led to the patient's death.[206] Dr. Swords maintained, however, that he had a phone consultation regarding his patient's condition two days subsequent to the patient's return from the hospital.[207] In addition, Dr. Swords asserted that, five days later, he examined the patient and found nothing unusual.[208] Dr. Swords further averred that he never knew of the patient's deteriorating condition because he was not contacted by either the hospital or the nursing home.[209] Instead, Dr. Swords claimed, the nursing home notified the on-call physician of the patient's ailing condition two days after Dr. Swords's visit.[210]

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been criminally charged for medical errors that are reported by the press. *See supra* note 26.

[200] *See* Gianelli, *supra* note 4, at 1. The grand jury found that Dr. Swords "'did unlawfully by act, procurement, or culpable negligence and without lawful justification, kill a human being, Homer Sherwood, by failing to provide necessary medical care, and said killing was not an excusable homicide nor murder.'" *Id.* The indictment carried a possible prison term of up to 15 years. *See id.*

[201] *See id.* at 2. The patient, Mr. Homer Sherwood, suffered from diabetes, Alzheimer's disease, and had survived several strokes. *See id.*

[202] *See id.*

[203] *See id.* (reporting that the diabetes continued to be controlled by oral medication at the nursing home).

[204] *See id.* (noting that the patient's blood sugar level was 1420 when admitted to the hospital).

[205] *See id.*

[206] *See* Gianelli, *supra* note 4, at 2. The coma resulted in hyperosmolarity and hyperglycemia, which proved to be toxic to the patient's brain, causing cerebral edema and cerebral hypoxia. *See id.*

[207] *See id.*

[208] *See id.*

[209] *See id.*

[210] *See id.* (noting that it was apparently the on-call physician who prescribed an antibiotic and admitted the patient to the hospital where the patient subsequently died).

Dr. Swords's attorneys contended that their client followed proper procedures for monitoring the patient's diabetes and further implied that, because there was no evidence that the doctor intended to harm the patient, there were no grounds for criminal liability.[211] Furthermore, the attorneys claimed that it was absurd for the state to single out Dr. Swords from all the other professionals who treated the patient prior to his death.[212] The doctor for the state responded that he had no input in the political or legal decision to prosecute Dr. Swords; rather, he was simply called as an expert witness to inform the jury about the appropriate standard of care for treating a diabetic patient.[213] The state alleged that Dr. Swords's conduct fell below the standard of care because he failed to examine the patient within forty-eight hours after the initial hospital discharge, in violation of a state requirement.[214] Dr. Swords's case never went to trial, however, because the charges against him were eventually dropped.[215] In both the cases of Dr. Einaugler and Dr. Swords, research did not reveal any evidence of disciplinary actions against the physicians prior to the incidents at issue.[216]

3. Dr. Benjamin

Dr. David Benjamin's case[217] marked the first time New York prosecutors charged a physician with the murder[218] of a patient.[219]

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[211] *See id.* One attorney for Dr. Swords commented, "'If alleged medical malpractice can be elevated to the criminal level without showing any intent to do harm on the part of the physician, then doctors across America are in a sorry state of affairs.'" *Id.* Another attorney for Dr. Swords remarked, "'I think physicians should be frightened by this indictment, because it says a doctor can be accused of a felony, a homicide, simply for treating a patient if the patient dies.'" *Id.* One of Dr. Swords' attorneys suggested, however, that, although the evidence in Dr. Swords' case was insufficient, criminal prosecution for the reckless conduct of physicians is under used in situations where a physician's failure to address a mistake in medical judgment could demonstrate that the physician was indifferent to the patient's welfare. *See* Oberman, *supra* note 17, at 2. As the attorney commented, "'[s]tupidity can elevate itself to reckless disregard.'" *Id.*

[212] *See* Gianelli, *supra* note 4, at 2.

[213] *See id.* An investigator in the case commented, "'[P]hysicians are not above the law. If the physician does not give a patient prudent treatment shouldn't he be subject to the law?'" *Id.*

[214] *See id.*

[215] *See* Oberman, *supra* note 17, at 2. No explanation was provided for why the charges were dropped. *See id.*

[216] *See* People v. Einaugler, 618 N.Y.S.2d 414, 414-16 (App. Div. 1994) (*Einaugler I*) (providing no mention of prior disciplinary actions); Gianelli, *supra* note 4, at 1-2 (same).

[217] Research has not revealed a reported court case for Dr. Benjamin. As explained earlier, however, the term "case" in this Note encompasses situations in

The patient bled to death on a clinic operating table after Dr. Benjamin fatally tore her cervix during the performance of an abortion.[220] Normally, a laceration of a patient's cervix does not constitute criminal conduct.[221] In this case, however, the state prosecuted Dr. Benjamin not for the medical error itself, but rather for deliberately neglecting the patient after the medical error.[222] Specifically, the doctor was indicted for recklessly performing the operation and then manifesting "depraved indifference to human life."[223]

Dr. Benjamin had been previously disciplined five times for bungled gynecological and obstetrical procedures.[224] In fact, Dr. Benjamin was practicing in Queens, New York, under an alias while he was under investigation by the state medical board for his practice in upstate New York.[225] Unlike the cases of Dr. Einaugler and Dr. Swords, this is a prime example of when criminal sanctions may be necessary as an additional mechanism for monitoring physician competence.

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which physicians have been criminally charged for medical errors that are reported by the press. *See supra* note 26.

[218] *See* N.Y. PENAL LAW § 125.25(2) (McKinney 1987) (explaining that "[a] person is guilty of murder in the second degree when . . . under circumstances evincing a depraved indifference to human life, he recklessly engages in conduct which creates a grave risk of death to another person, and thereby causes the death of another person").

[219] *See* Maier, *supra* note 4, at A35.

[220] *See* Bensel & Goldberg, *supra* note 3, at B10. According to authorities who investigated the case, the doctor, utilizing a procedure designed for a fetus younger than that of the patient, performed a second trimester abortion without determining why the patient suffered from high blood pressure. *See New York Abortion Doctor Indicted in Patient's Death*, ORLANDO SENTINEL, Aug. 13, 1993, at A10, *available in* 1993 WL 5240773.

[221] *See* Bensel & Goldberg, *supra* note 3, at B10.

[222] *See id.* Following a conviction for second-degree murder, Dr. Benjamin was sentenced to 25 years to life—the maximum penalty. *See id.*

[223] Oberman, *supra* note 17, at 2. In addition, there were allegations that Dr. Benjamin "misrepresented his knowledge of the gestation age of the fetus" and attempted to cover-up the cause of death by saying that the patient had suffered from cardiac arrest. Bensel & Goldberg, *supra* note 3, at B10.

[224] *See* Bensel & Goldberg, *supra* note 3, at B10.

[225] *See id.* Dr. Benjamin's treatment of Ms. Negron was first brought to the state medical board's attention in October 1992. *See* Oberman, *supra* note 17, at 2. Seven years earlier, however, the state board overturned a recommendation that Dr. Benjamin's license be revoked. *See id.* (quoting a spokesperson for the New York State Medical Board stating: "'As far as we were concerned this physician should've been out of practice in 1986 . . . . But the review process was moving forward as quickly as it could . . . . Unfortunately, during the period designed to give him due process, he continued to practice bad medicine.'").

## IV. ARGUMENTS FOR AND AGAINST THE PROSECUTION OF HEALTH CARE PROFESSIONALS

If the goal of quality assurance mechanisms is to protect consumers from incompetent physicians, then the use of criminal sanctions to exclude incompetent physicians from the medical profession appears to be a legitimate quality assurance mechanism. In fact, criminal sanctions may be the quality assurance mechanism necessary to compensate for the inefficiencies of traditional quality assurance mechanisms that rely on self-policing. As discussed previously, self-policing systems have been ineffective in the past at monitoring incompetent physicians because medical professionals are hesitant to punish their colleagues.[226] Furthermore, given that state licensing boards tend to be under-funded,[227] the use of criminal sanctions may become more frequent and necessary to exclude incompetent physicians from the medical profession. Consumer advocates encourage the use of criminal sanctions as a welcome alternative to protect consumers precisely because the system of self-policing, through licensing boards or institutional peer review committees, is time-consuming and has proven inadequate in many respects.[228]

Whether criminal sanctions or civil sanctions are desirable depends on the outcomes afforded by each sanction. Essentially, the distinction between civil sanctions and criminal sanctions is based on whether the defendant is required to compensate the individual victim for her loss or whether the defendant is required to pay society for the loss.[229] Given that criminal sanctions hold defendants accountable to society in general, criminal sanctions, more than civil sanctions, offer all consumers a mechanism of quality control.

Furthermore, if an additional role of criminal law, as some argue, is to educate the public about societal values and morals, criminal sanctions will encourage physicians to provide quality health

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[226] *See supra* notes 96-97 and accompanying text (highlighting physicians' resistance to pass judgment on one another).

[227] *See supra* notes 74-75 and accompanying text (discussing the effects that a lack of resources have upon quality assurance).

[228] *See supra* notes 95-99 and accompanying text (discussing the deficiencies of formal peer review systems).

[229] *See* State v. Weiner, 41 N.J. 21, 25, 194 A.2d 467, 469-70 (1963) (noting that unlike a civil case, in which the issue is whether the victim or tortfeasor will bear the financial cost of the loss, in a criminal case "[t]he injury to be vindicated is not the personal wrong suffered by the victim but rather an outrage to the State"); *see also* DOBBS ET AL., *supra* note 37, § 1, at 5-6 (explaining that the protection of societal interests is the goal of criminal law, whereas, the compensation for losses suffered by the individual is the goal of tort law).

care.[230] Failure to do so will result in the physician's exclusion not only from the medical profession but also from society in general.[231] This argument is based on a utilitarian notion that criminal sanctions are appropriate for negligent conduct because punishing negligent conduct encourages individuals to conduct themselves with more caution.[232] The utilitarian theory supports using criminal sanctions as a mechanism of controlling the quality of health care, be-

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[230] *See* John C. Coffee, Jr., *Does "Unlawful" Mean "Criminal"?: Reflections on the Disappearing Tort/Crime Distinction in American Law*, 71 B.U. L. REV. 193, 193-94 (1991). As John Coffee, Jr. explains:

> The factor that most distinguishes the criminal law is its operation as a system of moral education and socialization. The criminal law is obeyed not simply because there is a legal threat underlying it, but because the public perceives its norms to be legitimate and deserving of compliance. Far more than tort law, the criminal law is a system for public communication of values.

*Id.* (citation omitted).

[231] *See, e.g.*, ARK. CODE. ANN. § 17-93-409(1) (Michie 1992); IOWA CODE § 147.55(5) (1989); N.H. REV. STAT. ANN. §§ 329:17(VI)(c), (VI)(j) (1995); *see also supra*, note 88 (discussing the case of Dr. Klvana, who was sentenced to 53 years in prison); *supra* notes 177-98 (discussing the case of Dr. Einaugler, who was sentenced to 52 weekends in prison); *supra* notes 217-25 (discussing the case of Dr. Benjamin, who was sentenced to a prison term of 25 years to life).

[232] *See* DRESSLER, *supra* note 10, at 114. Although it is highly controversial to punish negligent conduct without proof of subjective fault, one justification for this practice is grounded in utilitarian principles. *See id.* at 113-14 (noting Oliver Wendell Holmes's blunt observation that "'public policy sacrifices the individual to the general good'"). Based on utilitarian principles, the justification for punishing negligent conduct is that society in general will benefit because individuals will be coerced to act more cautiously. *See id.*; *see also* Smith, *supra* note 4, at 132 (citing H.L.A. Hart, *Negligence Mens Rea and Criminal Responsibility*, *in* PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 136 (1968) (professing that negligent conduct should be held criminally culpable to encourage individuals to act more carefully); GLANVILLE WILLIAMS, TEXTBOOK OF CRIMINAL LAW 91 (1983) (endorsing punishment for negligent conduct on the ground that the individual may act better after being punished)).

For example, an ex-Navy surgeon who served two years in prison for the death of three patients (although later exonerated by an appeals committee) returned to the practice of medicine after his prison term but no longer practiced surgery. *See* Arnold Q. Collins, *Finding a Safe Harbor: Ex-Navy Physician Cleared in Deaths, in Civilian Practice*, AM. MED. NEWS, June 10, 1991, at 2, *available in* 1991 WL 4845714. The surgeon explained that he is more cautious in his practice as a result of being charged criminally for his connection in a patient's death:

> I see kids, but I won't see very sick ones . . . . I'll do office gynecology, but I won't operate. And I'll do orthopedic work - - but nothing big. In this office, we're not going to treat anyone if we're likely to have a dead patient or if we're likely to be sued . . . . And we're not on the frontiers of medicine . . . . There's nothing experimental, so you can feel very safe.

*Id.* (internal quotations omitted).

cause the threat of criminal sanctions would encourage, if not force, physicians to monitor their own practices.[233]

Another argument that justifies punishing physicians for negligent care, the retributive theory, posits that the term "criminal negligence" implies that the actor's risk-taking was grossly unjustified and therefore deserves punishment.[234] As one commentator reasoned, inadvertent risk-taking is "a fault in social interaction" that should be punished through criminal sanctions.[235] According to proponents of this argument, the actor's inattentiveness is culpable because the actor is not taking into consideration the impact her behavior has on the lives of others.[236] Based on this notion, the case of Dr. Einaugler[237] was correctly decided if the jury found that Dr. Einaugler knew the risk created by delaying the patient's transfer, but determined that he took the risk for no justifiable reason.

Retributive theorists who oppose criminally punishing negligent conduct argue that a just criminal system should only punish those who have voluntarily committed a wrong.[238] A retributive theory of criminal liability approves of punishing an actor who intentionally causes harm to another or who is aware that the conduct at issue creates an unjustified risk of harming others but proceeds anyway. It is unjust, based on this theory, to punish an actor for negligent conduct where the risk-taking is inadvertent and the actor is unaware that the conduct creates a risk of danger.[239]

In addition, critics of punishing negligent conduct question the deterrent value on which the above utilitarian argument is prem-

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[233] *See* DRESSLER, *supra* note 10, at 114.

[234] *See id.*

[235] FLETCHER, *supra* note 160, at 264.

[236] *See id.*

[237] *See supra* notes 177-98 and accompanying text (detailing Dr. Einaugler's prosecution).

[238] *See* DRESSLER, *supra* note 10, at 114. One commentator explains:

> The punitive urge to punish those who have caused harm, without any sophisticated moral assessment of the actor's state of mind, is always present in society and can easily turn the criminal law into an instrument of oppression. The medical profession is particularly vulnerable to this, as it may be perceived as exploitative or unaccountable, prompting the public to derive some pleasure form seeing members of the profession in the dock.

Smith, *supra* note 4, at 145.

[239] *See* DRESSLER, *supra* note 10, at 114 (citing Jerome Hall, *Negligent Behavior Should Be Excluded From Penal Liability*, 63 COLUM. L. REV. 632, 641 (1963)). *But see* Simons, *supra* note 153, at 397 (arguing that culpable indifference, where an actor "shows a grossly inadequate concern for a risk of harm" is an adequate threshold of culpability for criminal liability).

ised.[240] Specifically, critics argue that imposing criminal sanctions on a negligent actor is ineffective because a negligent actor, who by definition fails to recognize her dangerous conduct, would also fail to comprehend the potential threat of sanctions for such conduct.[241] Furthermore, it is argued that although negligent actors should pay for the injuries they cause, by compensating the injured party, those who act negligently do not deserve to lose their liberty and be stigmatized.[242]

Medical associations and physician groups argue that holding physicians criminally liable for clinical errors, without a clear finding of a subjective intent to harm a patient, sets a dangerous precedent.[243] Rather than encouraging physicians to practice more safely, some critics argue that such a precedent will drive physicians away from taking hard cases or experimenting in new areas.[244] Others argue that the threat of criminal sanctions will result in the practice of defensive medicine, which will increase health care costs and may even harm patients.[245] In addition, the medical profession is con-

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[240] *See* Hall, *supra* note 239, at 641.

[241] *See id.*

[242] *See* DRESSLER, *supra* note 10, at 114; *see also* Gianelli, *supra* note 4, at 2 (quoting an attorney defending a physician against criminal charges: "If alleged malpractice can be elevated to the criminal level without showing any intent to do harm on the part of the physician, then doctors across America are in a sorry state of affairs"); Maier, *supra* note 4, at A35 (quoting a spokesperson for a medical society as stating: "This [prosecuting doctors for deadly medical errors] is a dangerous precedent to set because human beings can make errors"); Howard Pankratz, *Vigilance Failure Charged Anesthesiologist on Trial in Death of Boy During Surgery*, DENV. POST, Oct. 3, 1996, at B1, *available in* 1996 WL 12632961 (reporting that a defense attorney admitted that the doctor may have committed malpractice, but argued that he did not make the challenged medical decision with criminal intent); *Police Seek*, *supra* note 2, at C6 (quoting an attorney representing a nurse in a case where the accidental administration of the wrong drug resulted in the patient's death: "We should worry about people who intentionally go out and violate the law . . . . I just think it would be a mistake to involve the criminal system."). In the case of the former Navy surgeon, *see supra* note 232 and accompanying text, it was reported that an appeals court, which overturned the surgeon's manslaughter and negligent homicide convictions, accused prosecutors of mounting a "'smear campaign' and attempt[ing] to impute criminal liability." Collins, *supra* note 232, at 2.

[243] *See* Maier, *supra* note 4, at A35 (quoting a New York State Medical Society spokesperson as stating: "The specter of criminality may make doctors shy away from more difficult cases. No professional is prepared to go to jail for making an error in clinical judgment."); *see also supra* note 4 (discussing the profession's concern over increased prosecutions).

[244] *See* Lindsay IV, *supra* note 129, at 17A (quoting the AMA's warning that charging doctors criminally for medical errors would be "'a disaster for patients'").

[245] *See, e.g.*, Gianelli, *supra* note 4, at 2 (noting that the Florida Medical Association's general counsel warned that if the state is "looking over [doctors'] shoulders" every time the treatment of a patient results in death, doctors will be wary of treat-

cerned that attorneys and lay juries will usurp the role of medical experts in defining the appropriate standard of care.[246]

## V. CONCLUSION

Ultimately, the prosecution of health care professionals presents an effective additional mechanism to assure quality health care. The current mechanisms of civil sanctions and disciplinary actions are insufficient to punish adequately health care professionals who intentionally harm patients or consciously disregard a substantial and un-

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ing patients); Lindsay IV, *supra* note 129, at 17A (reporting that the chairwoman of the AMA warned that doctors will grow fearful of making medical decisions if they are prosecuted for medical errors); Smith, *supra* note 4, at 144 (explaining that medical professionals have argued that because errors in medicine are inevitable due to the complex nature of the activity, labeling these errors as criminal will result in the practice of defensive medicine). It is estimated that the practice of defensive medicine costs from $20 to $25 billion annually. *See, e.g.*, Jost, *supra* note 55, at 74; Lozano, *supra* note 46, at 40. *But see* HARNEY, *supra* note 22, at 417 (observing that although health care professionals and insurance companies argue that the practice of defensive medicine is very costly to the public, in the author's 35 years of experience handling medical malpractice cases he never came across a case in which a health care professional actually practiced defensive medicine); Jost, *supra* note 5, at 574 n.286 (noting that some commentators argue that the extent of the practice of defensive medicine is exaggerated as there is little data to support the claim). For a more detailed discussion on the role of civil liability and the practice of defensive medicine see Robinson, *supra* note 50, at 175-80.

[246] *See* Oberman, *supra* note 17, at 2. The district court in *Einaugler* was troubled by the fact that lay juries in a criminal case may be responsible for determining the appropriate standard of medical care without the assistance of medical experts. *See* People v. Einaugler, 918 F. Supp. 619, 627 (E.D.N.Y. 1996) (*Einaugler II*), *aff'd*, 109 F.3d 836 (2d Cir. 1997) (*Einaugler III*). In pertinent part, the court stated:

> What makes this a troubling case is that none of the witnesses called by the prosecution testified directly that the delay [in transferring the patient from the nursing home to the hospital] created even a risk of death, much less a quantifiable risk of death, and that a lay jury in a criminal case was forced to deduce this critical element of the offense from circumstantial evidence. Even in civil medical malpractice cases, New York law recognizes that the intricacies of medical practice are beyond the competence of the ordinary lay person and that without expert assistance, jurors cannot reliably evaluate the contentions of the parties. Such testimony is especially important on the difficult issue of causation.

*Id.* Nevertheless, after reviewing several physicians' testimony, none of whom specifically addressed the issue of causation, the court held that "although this is a close call . . . there was sufficiently comprehensive evidence for the jury to make a rational assessment of the relevant risk." *Id.* at 631. The appellate court also recognized that expert testimony on the risk of death caused by the delay would have strengthened the state's case against Dr. Einaugler, but determined that medical expert testimony was not necessary in this particular case because the testimony of a medical expert has never been required under New York criminal law in a reckless endangerment case. *See Einaugler III*, 109 F.3d at 841-42.

justifiable risk. The criminal law should not, however, operate in isolation from these current mechanisms. Unlike in other areas of law, the customs of this profession define the standard of care to which physicians are held; therefore courts require a medical professional's expertise.[247] Rather than merely coexisting, the civil and criminal systems should operate cooperatively so that civil sanctions afford physicians an opportunity to correct their incompetence, while at the same time, consumers are protected when the corrective civil system fails.[248] For example, in such a system prosecutors could seek the aid of medical experts, perhaps those medical experts who sit on state licensing boards, before charging a physician with a crime. In this way, a physician's incompetence would be brought to the attention of medical experts who could then determine whether the clinical error constitutes civil negligence requiring only civil sanctions or whether the clinical error rises to the level of criminal negligence, thereby justifying the criminal prosecution of the physician.[249] In sum, the current mechanisms of professional regulation are wholly inadequate at monitoring physicians. As such, the additional threat of criminal sanctions for fatal clinical errors would serve to deter physicians from the provision of incompetent medical care and thereby further assure quality health care to consumers.

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[247] *See supra* notes 41-42, 49-52 and accompanying text (discussing the standard of care applied in medical malpractice suits).

[248] *See, e.g.*, Oberman, *supra* note 17, at 2.

[249] *See id.* (reporting that a physician, the former president of a medical society, suggested that expert medical panels should be convened before criminal charges are instituted against a physician "to better distinguish criminal conduct from understandable mistakes").