

PHYSICIANS WHO BREAK THE LAW

DIANE E. HOFFMANN*

*The medical profession has, of course, many dedicated people who give of themselves and literally sacrifice their own interests for the sake of their patients. The point is that medicine has its share of both angels and scoundrels.*¹

INTRODUCTION

In her article, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, Sandra Johnson focuses on doctors who comply with the law despite their belief that the law is "bad," i.e., causes them to behave in ways that are harmful to their patients.² Physicians who obey laws they claim are bad may hurt patients by failing to treat them or treating them inappropriately. They may under-medicate their patients or subject them to unnecessary procedures or tests. These laws may also have a "chilling effect" on physician behavior, causing them not only to inadequately treat their own patients but also to refuse to see certain types of patients, e.g., those who are "the sickest or highest-risk,"³ or to provide patients with certain kinds of

* Professor of Law; Associate Dean for Academic Programs; and Director, Law and Health Care Program at the University of Maryland School of Law. I would like to express my thanks to my colleagues Richard Boldt, Sandra Johnson and Jack Schwartz for comments on earlier drafts of this article and to research fellow, Susan McCarty, for her invaluable assistance.

1. DAVID MECHANIC, *MEDICAL SOCIOLOGY* 116 (2d ed. 1978), *quoted in* Paul D. Jesilow et al., *Medical Criminals: Physicians and White-Collar Offenses*, 2 JUST. Q. 149, 163 (1985).

2. Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973 (2009). Johnson provides the following examples of bad law claims:

[M]alpractice litigation that makes doctors practice "defensive medicine"; . . . patients' rights that make doctors provide futile care; . . . controlled substances laws that require [doctors] to neglect their patients in pain or to deny their patients the sterile injection tools that would prevent the spread of disease; . . . antitrust laws that prevent doctors from organizing themselves in ways that would produce more cost-effective and accessible care; and . . . regulations that impede important medical research.

Id. at 974-75 (footnotes omitted).

3. John Liederbach et al., *The Criminalization of Physician Violence: Social Control in Transformation?*, 18 JUST. Q. 141, 165 (2001).

treatment or services.⁴ Such physicians may be described as overly cautious or as “over-complying” with the law. They stay far away from the line demarcating what is legal and illegal.⁵

There are a number of reasons why physicians might over-comply with the law, e.g., the law’s complexity and uncertainty, the fact that they misunderstand the law, or the possibility that they have unique personal characteristics that make them more sensitive (i.e., risk averse) to entanglements with the law.⁶ Research on the deterrence value of law has shown that “[p]eople who have conventional values or strong social ties are . . . easier to deter, possibly because arrest—or other legal action—brings the offence to the attention of other (conventional) people who matter to them and thereby jeopardise valued social relationships.”⁷ In the case of physicians, such action would also significantly affect their reputation, and thus may lead to hypersensitivity to possible arrest for violation of the law.

4. See, e.g., Lawrence O. Gostin, Commentary, *Abortion Politics: Clinical Freedom, Trust in the Judiciary, and the Autonomy of Women*, 298 JAMA 1562, 1563 (2007) (arguing that the Partial-Birth Abortion Ban Act, upheld by the Supreme Court in *Gonzales v. Carhart*, 550 U.S. 124 (2007), will have a chilling effect on physician willingness to perform procedures used to end medically dangerous pregnancies); Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 231, 309 (2008) (describing the chilling effect of the Controlled Substances Act and its enforcement on physician willingness to treat chronic pain patients or to prescribe opioids for pain management); Blaine Harden, *Court Rules on Aided Suicide*, WASH. POST, May 27, 2004, at A2 (stating that the 2001 “Ashcroft Order,” regarding the illegality of prescribing controlled substances for assisted suicide, had a chilling effect on Oregon physicians carrying out requests under Oregon’s assisted suicide law).

5. These physicians practice in a way that is in the 40%–60% range, rather than the 30%–70% range, of the safe harbor that Professor Johnson describes. See Johnson, *supra* note 2, at 1018–22. Johnson uses an illustration to show how doctors often operate well inside the “safe harbor” range. She asks the reader to

assume a range of interventions from 1 to 100, and that the range of appropriate treatment lies between 10 to 90. To retain a margin for prosecutorial or regulatory discretion in individual cases, the clinical safe harbor is set to cover behavior in the range of 30 to 70. This means that while doctors practicing in the range between 10 and 30 and between 70 and 90 are engaged in legitimate medical practice, they simply are not guaranteed protection from government scrutiny.

Id. at 1021. She asserts, “[t]he risk-averse doctor who fears investigation and potential prosecution by enforcement agencies and the rational doctor who calculates the risks and benefits of choosing to treat one type of patient over another both stay well within the identified safe harbors.” *Id.*

6. See *id.* at 978 (stating that there has been some research on the training of physicians indicating that they have a “heightened sensitivity to shame associated with errors, a refined notion of the centrality of character, and the attachment of serious moral content to breaches of particular, but not all, standards of behavior”).

7. Jonathan P. Shepherd, *Criminal Deterrence as a Public Health Strategy*, 358 LANCET 1717, 1719 (2001) (footnote omitted).

Physicians who over-comply with the law may also overestimate the probability of being identified or captured in a law enforcement net. Stories in the media about physicians who are arrested and prosecuted, that focus on arbitrary or prejudicial enforcement, also undoubtedly fuel physician fears of the law.⁸

While the large majority of physicians operate within the law, there are some who do not. These physicians may not share the same personal traits as other physicians that lead to hypersensitivity of being caught for lawbreaking. In this essay, I explore why physicians break the law, how law enforcement responds when they do, and what, if anything, we can learn from cases about physicians who break the law, about the laws they break and their enforcement. In this exploration, I focus on two areas of physician lawbreaking: (1) violations of business-related laws (non-clinical), and (2) violations of laws relating directly to patient care. The first area deals primarily with physician failure to comply with laws addressing insurance fraud; the second, with situations where physicians violate the law in order to provide what they believe is clinically appropriate care to their patients.

I. PHYSICIANS WHO BREAK FRAUD LAWS

Some of the most common violations of the law by physicians involve insurance fraud, overstepping sexual boundaries, and drug abuse or diversion of controlled substances.⁹ The question of why physicians engage in violations of the law in these areas has been underexplored in the literature.¹⁰ The reasons, no doubt, differ with the type of crime. Although none of these crimes by physicians have been studied extensively, insurance fraud appears to be the most common type of lawbreaking by physicians and the crime for which there is the most abundant information. Insurance fraud involves crimes

8. See, e.g., Hoffmann, *supra* note 4, at 239–40 (describing the case of Dr. Frank Fisher, who spent five months in jail prior to a hearing at which the charges against him for murder were dismissed or reduced and later dropped due to insufficient evidence); see also Chad D. Kollas et al., *Criminal Prosecutions of Physicians Providing Palliative or End-of-Life Care*, 11 J. PALLIATIVE MED. 233, 235 (2008) (describing the case of Dr. Robert Weitzel, in which the prosecutor failed to disclose exculpatory evidence).

9. See George J. Annas, *Medicine, Death, and the Criminal Law*, 333 NEW ENG. J. MED. 527, 527 (1995) (“Criminal charges related to the practice of medicine have primarily involved insurance fraud (including Medicare and Medicaid fraud), sexual abuse of patients, or illegal use or prescription of controlled substances.”).

10. See Jesilow et al., *supra* note 1, at 149, 151–52 (“Few textbooks on deviance or criminology attend to offenses by physicians, probably because of the respect, power, and trust that the profession engenders. In addition, there is little systematic investigative or social science work on the range of illegal medical acts. In part, this results because access to information is difficult to obtain, as the strength of the profession has served to protect it from close scrutiny.” (citation omitted)).

in which physicians knowingly defraud commercial or government insurers, in particular, Medicare and Medicaid, by making a false statement or representation in connection with payment for services rendered or participation in an insurance program.¹¹ The laws governing these behaviors, at their most basic level, apply a generally accepted moral value (i.e., do not steal) to our current government and commercial health insurance programs.

Insurance fraud is considered a type of white-collar crime,¹² and while much of white-collar crime focuses on corporate offenses, these crimes also include lawbreaking by professionals. Perhaps the first person to write about physicians as white-collar criminals was Edwin H. Sutherland. In his 1949 book, *White Collar Crime*,¹³ Sutherland included crimes by doctors, as he believed studying their violations of the law could provide “particularly important information in assessing why persons who seemingly have no ‘real’ or ‘true’ need to enrich themselves nevertheless do so by illegal means.”¹⁴ In the book, Sutherland listed the types of crimes committed by doctors at the time. They included “illegal sales of alcohol and narcotics, abortion, illegal services to underworld criminals, fraudulent reports and testimony in accident cases, fraud in income tax returns, extreme instances of unnecessary treatment and surgical operations, fake specialists, restriction of competition, and fee-splitting.”¹⁵

Today, doctors commit white-collar crimes when they take kickbacks on referrals or prescriptions, order questionable procedures or inaccurately report procedures, overbill patients and insurers, bill for services they have not provided, or bill for patients and clinical entities that do not exist. Empirical research on why physicians commit white-collar crime reveals that, for the most part, it is for the same reasons that other professionals do: the belief, which is in large part true, that the probability of getting caught is low,¹⁶ the opportunity is readily available, and the reward is potentially great. White-collar crimes, such as fraud, are also relatively easy to hide and hard to

11. Such false billing involving federal health care plans constitutes a federal crime and, in most cases, a felony. See BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 1009 (5th ed. 2004).

12. 1 *ENCYCLOPEDIA OF WHITE-COLLAR & CORPORATE CRIME* 317 (Lawrence M. Salinger ed., 2005).

13. EDWIN H. SUTHERLAND, *WHITE COLLAR CRIME* (1949).

14. Jesilow et al., *supra* note 1, at 152 (discussing Sutherland’s view on doctors’ violations of the law). The authors further state that “Sutherland was also interested in decimating contemporary theories which insisted that Freudian complexes, immigrant status, and poverty ‘caused’ crime: doctors and other white-collar criminals, he noted, rarely fell into such categories.” *Id.*

15. SUTHERLAND, *supra* note 13, at 12.

16. Relative to their incidence, arrests are very rarely made. White-collar crime is rarely prosecuted, and individuals who are prosecuted are rarely convicted. ERICH GOODE, *DEVIANANT BEHAVIOR* 218–19 (8th ed. 2008).

detect.¹⁷ The acts tend to “be made up of complex, sophisticated, and relatively technical actions” and “intermingled with legitimate behavior.”¹⁸

In a 1991 *JAMA* article, *Fraud by Physicians Against Medicaid*,¹⁹ the authors report on their interviews of over forty physicians who ran afoul of the Medicaid fraud and abuse laws. They consistently found that the physicians viewed the violation as easy—there was no known victim, only an impersonal billing process—and they simply had to check a procedure on a form that was more expensive than the procedure actually performed, or inflate the amount of time they spent with a patient.²⁰

Physicians, like other professionals, also engage in white-collar crimes for personal reasons such as striving to achieve a certain lifestyle or because of an economic or family crisis. The literature indicates that white-collar criminals are motivated by two factors: economic difficulty and greed.²¹ Often the behavior that enables a physician to engage in fraud is partially learned from others in the profession as “professional values may effectively neutralize [the doctor’s] conflicts of conscience.”²² In justifying Medicaid fraud, for example, some physicians said they did it to make back what was owed them, alluding to the low Medicaid reimbursement rates.²³ Moreover, “occupational norms may support an attitude on the part of some professionals that they are ‘above the law.’”²⁴

Interviews with physicians prosecuted for Medicaid fraud revealed a group of people reluctant to say that greed was the reason for their behavior; they were more likely to attribute it to carelessness and to see themselves as “sacrificial lambs hung out to dry” by disgruntled employees, “stupid laws,” or “bureaucratic nonsense.”²⁵ They also felt that the Medicaid rules, which can be “mercilessly nitpicking,” stood “in the way of important and humane service demands.”²⁶ They resented the outside control of these regulations on

17. *Id.*

18. *Id.*

19. Paul Jesilow et al., *Fraud by Physicians Against Medicaid*, 266 JAMA 3318 (1991).

20. *Id.* The authors provide examples of physicians who billed 4800 hours in a year, who billed for services to persons who were dead, or billed for services when they were on vacation. *Id.* at 3319. One physician performed abortions on women who were not pregnant and in one case on a woman who had had a hysterectomy. *Id.*

21. See ALEX THIO, *DEVIAN'T BEHAVIOR* 343–44 (6th ed. 2001) (discussing the causes of white-collar crime).

22. Jesilow et al., *supra* note 19, at 3321.

23. *Id.* at 3320.

24. See PAUL JESILOW ET AL., *PRESCRIPTION FOR PROFIT: HOW DOCTORS DEFRAUD MEDICAID* (1993), as reprinted in *ABOUT CRIMINALS* 156 (Mark Pogrebin ed., 2004) (“A subculture of medical delinquency . . . arises, thrives, and grows in large part because of the tension between bureaucratic regulation and professional norms of autonomy.”).

25. Jesilow et al., *supra* note 19, at 3320.

26. JESILOW ET AL., *supra* note 24, at 150.

their independence and autonomy.²⁷ An example given by one physician prosecuted for Medicaid fraud was his treatment “of a fourteen-year-old girl who was having her third abortion in less than six months. He had given the girl birth control pills, but she obviously hadn’t taken them. When she came back for the third abortion, he coaxed her into allowing him to insert an IUD,” telling her he could insert it right after he performed the abortion.²⁸ Medicaid would not pay for the IUD insertion because the IUD was “done at the same time as the abortion.”²⁹ The physician “subsequently got into difficulty in part by falsifying the dates that he did the two procedures.”³⁰

Clearly, this physician viewed the law that prevented him from billing for the procedure under these circumstances as “bad law.” The rule was established in light of the fact that when the two covered procedures are performed together the cost to the physician of the insertion of the IUD is nominal—the small cost of the IUD and the minimal extra time to insert it.³¹ Before the advent of Medicaid, the physician might have performed such a service for free, yet, in this case, he was not willing to forgo the additional small expense of the IUD insertion. Instead, he felt cheated because he was unable to charge for the full cost of the procedure (which included a new office visit).³² He chose to frame the issue as one in which his patient would be harmed if he required her to come back for a second visit as she would be unlikely to return and might become pregnant again.³³

The view that the Medicaid rules and their enforcement are unfair and irrational was a common perspective among those interviewed. One respondent “insisted that Medicaid not only invited but demanded cheating.”³⁴ He appeared to resent the fact that the enforcers were not “medical people” and described them as knowing “nothing about the services being provided.”³⁵ He defended his actions by saying:

They’ve built in systems that either ask for somebody to cheat . . . or to cheat the patient on the type of care that’s provided. You put somebody in the position where lying is the most reasonable course, and they will lie. The

27. *See id.* at 156.

28. *Id.* at 153.

29. *Id.*

30. Jesilow, *supra* note 19, at 3320.

31. JESILOW ET AL., *supra* note 24, at 154.

32. *Id.*

33. *Id.* at 153. The case description does not indicate whether the alleged wrongdoing occurred before or after the 1976 Hyde Amendment, which prohibited Medicaid payment for abortion except under narrow circumstances. *See* Hyde Amendment of 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (codified as amended at 42 U.S.C. § 1397ee(c)(1), (7) (2000)). Most likely, however, it occurred prior to 1976 when many states covered abortions under Medicaid.

34. JESILOW ET AL., *supra* note 24, at 154.

35. *Id.*

patients will lie; the doctor may even lie on what they say about what happened.³⁶

Physicians may obtain their views about compliance with the Medicare and Medicaid programs as early as medical school. In a study of medical student attitudes toward physicians who committed Medicare or Medicaid fraud, Keenan et al. gave students a series of hypotheticals, based on real cases, in which physicians violated the fraud and abuse laws and asked them what sort of sanctions the physicians should receive for their violations of the law.³⁷ Thirty-five percent (35%) of the respondents blamed the government programs, rather than the physicians, for violation of the program rules.³⁸ The students cited several programmatic features as contributors to physicians' fraudulent behavior. These included the low level of reimbursement, the paperwork and bureaucracy, and the programs' inefficiency.³⁹ By blaming the programs, the students shifted the responsibility for the wrongful acts away from the physicians and toward the flaws of the programs themselves.⁴⁰ The authors concluded that "[s]tudents believed that the regulations and policies governing these programs actually promoted fraud and abuse among physicians, despite the voluntary nature of physician participation."⁴¹

Physicians may also engage in private insurance fraud, which can be the basis of criminal arrest and prosecution under various state laws⁴² as well as under the federal Health Insurance Portability and Accountability Act (HIPAA).⁴³ In the 1990s, due to the use of utilization review in managed care plans, many physicians reported pressure to alter a patient's medical records to support insurance coverage for the patient's treatment. In a survey of over 700 physicians, Wynia et al. sought to determine "whether financial pressures, practice characteristics, and/or . . . personal characteristics influence physicians' use of deception with third party payers."⁴⁴ The survey was

36. *Id.* at 155.

37. Constance E. Keenan et al., *Medical Students' Attitudes on Physician Fraud and Abuse in the Medicare and Medicaid Programs*, 60 J. MED. EDUC. 167 (1985).

38. *Id.* at 172.

39. *Id.*

40. *Id.*

41. *Id.*

42. See, e.g., Illinois Insurance Claims Fraud Prevention Act, 740 ILL. COMP. STAT. ANN. 92/1 to 92/45 (2002); New Jersey Insurance Fraud Prevention Act, N.J. STAT. ANN. §§ 17:33A-1 to -30 (West 1994 & Supp. 2008).

43. Health Insurance Portability & Accountability Act of 1996, Pub. L. No. 104-191, §§ 241-50, 110 Stat. 1936, 2016 (codified in scattered sections of 18 U.S.C. (2006)).

44. M. Wynia et al., *Physician Responses to Utilization Review Pressures: Results of a National Physician Survey*, in SELECTED PAPERS FROM THE ASS'N HEALTH SERVICES RESEARCH ANNUAL MEETING JUNE 21-23 1998, at 244 (1999) [hereinafter Wynia, *Physician Responses to Utilization Review Pressures*], available at <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102193686.html>. The study results were published in further detail in *JAMA*.

conducted in 1998 and the results were reported at a 1999 meeting of the Association of Health Services Researchers. Of the 61% who responded,

28% had exaggerated the severity of patients' conditions to help them avoid early discharge from the hospital; 23% had changed official (billing) diagnoses to help patients secure coverage for needed treatments or services; and 9% had reported symptoms that patients did not actually have to help them secure coverage for needed treatments.⁴⁵

Those physicians who engaged in these deceptive practices were more likely than their colleagues to be "less satisfied with medical practice, less financially secure, . . . less likely to report having enough time during patient visits, more likely to find insurance company intrusions annoying, and more likely to believe that 'gaming the system' for patients was necessary to provide high quality care."⁴⁶ Moreover, these physicians were not swayed by the threat of prosecution as they believed their actions were necessary for the health of their patients. Interestingly, while a large majority of respondents (87%) believed that all physicians had a responsibility to try to contain health care costs, 55% said "they would be more aggressive in cost control efforts if they knew that money saved would go towards serving more needy patients."⁴⁷

While fraud laws are an effort to protect the public purse and insurance monies that are part of a communal fund, and they may also protect patients (e.g., from unnecessary procedures), physicians claim complying with them may hurt patients. This claim often reflects a misconception, however, when it is not compliance with the fraud laws that hurts patients but compliance with some other law, regulation, or policy. For example, physicians may violate commercial insurance fraud regulations because they disagree with the insurance policies or the interpretation of the policies by the insurance company. Most often this occurs when it is the physician's medical opinion that the proposed treatment or continued treatment is medically necessary. In the context of Medicare and Medicaid fraud, it is the billing rules that some physicians argue encourage care that harms patients, e.g., rules that encourage physicians to have patients come back for a second visit in order to charge for a procedure that could be done during the first visit.⁴⁸

Matthew K. Wynia et al., *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 JAMA 1858, 1861 (2000) [hereinafter Wynia, *Physician Manipulation of Reimbursement Rules for Patients*].

45. Wynia, *Physician Responses to Utilization Review Pressures*, *supra* note 44, at 244.

46. *Id.*

47. *Id.*

48. See Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006, 70 Fed. Reg. 70116, 70261 (Nov. 21, 2005) (stating that the Centers for Medicare and Medicaid Services (CMS) reimburses a same-visit, second procedure at 50% of the fee schedule rate, and that "the multiple procedure payment reduction for surgery . . . has been a longstanding policy").

II. HOW THE CRIMINAL JUSTICE SYSTEM TREATS PHYSICIANS WHO VIOLATE FRAUD LAWS

When physicians intentionally violate the fraud laws, most of us would agree that they should be punished, perhaps more harshly than nonprofessionals who commit more routine street-crimes, given their privileged position in society. Yet white-collar criminals, more broadly, are perceived to be treated less harshly than nonprofessionals. There is little data, however, to determine whether that perception is valid.⁴⁹ Whether or not physicians who commit fraud are treated more or less harshly by the criminal justice system requires information about several components of the system: at the front end, whether physicians are arrested and prosecuted more frequently than non-physicians engaging in similar crimes; and at the back end, whether physicians are convicted more or less frequently and whether they are sanctioned more or less harshly than non-physicians committing similar crimes.

As regards law enforcement efforts to identify and arrest physicians who engage in fraud, considerable resources are being used to detect and combat medical fraud. At the federal level, such efforts by the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) were “consolidated and strengthened” by the passage of HIPAA.⁵⁰ In enacting HIPAA, Congress directed the Secretary of DHHS and the Attorney General to establish a “joint Health Care Fraud and Abuse Control Program and created a dedicated funding stream for health care fraud and abuse control activities.”⁵¹ Resources devoted to Medicaid fraud control at the state level have also increased.⁵² The additional resources for detection of physicians engaging in

49. In fact, there is some evidence to show the opposite. Based on a vignette study, Rosoff found that “for serious offenses (homicides not related to medical practice), respondents allocate harsher verdicts to physicians with higher-status specialties.” Liederbach et al., *supra* note 3, at 163 (citing Stephen M. Rosoff, *Physicians as Criminal Defendants: Specialty, Sanctions, and Status Liability*, 13 LAW & HUM. BEHAV. 231 (1989)). Also, Shaw and Skolnick found that an offender’s status may “increase harshness [of the sanction] when the [offense] is related to professional practice (an altercation in the office with a patient).” *Id.* (citing Jerry I. Shaw & Paul Skolnick, *When Is Defendant Status a Shield or a Liability?: Clarification and Extension*, 20 LAW & HUM. BEHAV. 431 (1996)).

50. See U.S. DEP’T OF HEALTH & HUMAN SERVICES & U.S. DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FY 1998 (1999), http://www.usdoj.gov/dag/pubdoc/98hipaa_ar.htm [hereinafter DHHS & DOJ, ANNUAL REPORT].

51. *Budgeting to Fight Waste, Fraud and Abuse: Hearing Before the H. Comm. on the Budget*, 110th Cong. 8 (July 17, 2007) (statement of Mike O. Leavitt, Secretary, U.S. Department of Health & Human Services).

52. Jeffrey Blumengold & Christopher Panczner, *ForThoughts—Edition 5: The Shifting Landscape of Health Care Fraud and Regulatory Compliance*, DELOITTE, <http://www.deloitte.com/dtt/article/0,1002,cid%253D218791,00.html> (last visited May 12, 2009).

fraud and abuse have significantly increased the number of physician arrests and prosecutions.⁵³

While insurance fraud continues to be difficult to detect, law enforcement agents are assisted in their efforts by False Claims Act relators or “whistle-blowers.”⁵⁴ In some cases, the relator may be a prior employee, in others he or she may be a patient. Relators are entitled to a percentage of the government’s recovery and therefore have an incentive to come forth with information.⁵⁵ More recently, law enforcement agencies have created programs to “ferret out fraud through data matching, data mining, and . . . the hiring of contractors to go out as third parties to look for fraud, waste, abuse, or errors.”⁵⁶

In order to determine whether physicians are treated differently than nonprofessionals once they are arrested, we would need to know whether they are more or less likely to be prosecuted and convicted. Writing twenty-five years ago, Jesilow, Pontell, and Geis asserted that “[t]he status of doctors preclude[d] the rough and insensitive treatment often accorded to street offenders,”⁵⁷ and quoted a federal agent in support of their observation who said:

U.S. attorneys are extraordinarily kind to doctors, because even if they are crooks, theoretically they’re still providing some useful services for the community. . . . There’s a double standard for doctors because there aren’t many other categories of white-collar criminals that are looked upon as a community of people who save lives.⁵⁸

Today, that does not appear to be the case, at least with respect to health care fraud. According to a joint annual report by DHHS and DOJ, “[f]ederal prosecutors filed 322 criminal health care fraud cases in 1998—a 14 percent increase over the previous year.”⁵⁹ During that same year, “326 defendants

53. See RONALD T. LIBBY, *THE CRIMINALIZATION OF MEDICINE: AMERICA’S WAR ON DOCTORS* 40 (2008) (“The number of fraud investigators in the OIG of HHS increased by 40 percent from 1998 to 2005. In 1998, there were 260 auditors and 136 criminal investigators. In 2006, there were 1,500 investigators and attorneys.”). In addition, “FBI health fraud investigations increased by more than 400 percent from 591 in 1992 to 2,547 cases in 2005.” *Id.*

54. See Joan H. Krause, *A Patient-Centered Approach to Health Care Fraud Recovery*, 96 J. CRIM. L. & CRIMINOLOGY 579, 585 (2006) (discussing the False Claims Act’s status as the “centerpiece of the government’s anti-fraud efforts”).

55. See *id.* (noting that relators can “retain fifteen to thirty percent of the proceeds”). See also U.S. DEP’T OF HEALTH & HUMAN SERVICES & U.S. DEP’T OF JUSTICE, *HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM: ANNUAL REPORT FOR FY 2007* 5 (2008), available at <http://www.usdoj.gov/dag/pubdoc/hcfacreport2007.pdf> (reporting that \$122 million in recovered funds were awarded to relators in fiscal year 2007).

56. Blumengold & Panczner, *supra* note 52.

57. Jesilow et al., *supra* note 1, at 161.

58. *Id.* (alteration in original).

59. See DHHS & DOJ, *ANNUAL REPORT*, *supra* note 50.

were convicted of health care fraud-related crimes.”⁶⁰ A decade later, “[i]n fiscal year 2007, the federal government alone initiated 878 criminal . . . investigations . . . and was successful in obtaining 560 criminal convictions.”⁶¹

While in many cases the physicians enter into a plea bargain with the prosecutor, if the case goes to trial, often the outcome is based on the sympathies of the jury and the judge. As regards whether white-collar criminals (not physicians specifically) are incarcerated more or less frequently than others, in 2002 Paul Rosenzweig, a Senior Research Fellow in the Center for Legal and Judicial Studies at the Heritage Foundation, testified on the question before the Senate Subcommittee on Crime and Drugs.⁶² Based on an empirical study of past crimes, he found that when one controls for non-discretionary sentencing (i.e., takes out crimes that were subject to federal sentencing guidelines and just looks at those where judges had discretion as between incarceration and a non-jail alternative) the results are equivocal—professionals have not been treated less harshly or more harshly than others.⁶³ Lengths of prison sentences, however, have been largely determined by the Federal Sentencing Guidelines, which were put in place to address sentencing disparities. In establishing the Guidelines, the Federal Sentencing Commission looked at past practices and collected data on more than 40,000 cases.⁶⁴ While the Commission was guided by historical data, it chose to depart from past practices in crimes of an economic or regulatory nature, as those crimes had been punished “less severely than other apparently equivalent behavior.”⁶⁵ Consequently, the Guidelines made “an effort to upgrade the penalties for regulatory and economic, white-collar offenses.”⁶⁶ In addition, Rosenzweig found that “courts d[id] not appear to depart from the [federal sentencing] guidelines with any greater frequency in white-collar cases than in street-crime cases.”⁶⁷

60. *Id.*

61. Blumengold & Panczner, *supra* note 52.

62. *Penalties for White Collar Crime: Hearing Before the Subcomm. on Crime and Drugs of the S. Comm. on the Judiciary*, 107th Cong. 144 (2002) [hereinafter Rosenzweig Testimony] (testimony of Paul Rosenzweig, Senior Legal Research Fellow, Center for Legal and Judicial Studies, The Heritage Foundation).

63. *Id.* at 148.

64. *Id.* at 151.

65. *Id.* (internal quotation marks omitted).

66. *Id.*; see also Liederbach et al., *supra* note 3, at 147 (stating that historical inequities in the treatment of white-collar and street-crimes have led to a “commitment to equal treatment under the law”).

67. Rosenzweig Testimony, *supra* note 62, at 150. Rosenzweig’s analysis was based on decisions made before 2005, when the Supreme Court in *United States v. Booker*, 543 U.S. 220 (2005), found that the Federal Sentencing Guidelines as originally constituted violated the Sixth Amendment right to trial by jury and struck down provisions of the law making them mandatory. The Federal Sentencing Guidelines are now advisory—judges are not required to follow them but

There is no specific data as to whether physicians are incarcerated with any more frequency than non-physicians or whether they are subject to shorter or longer prison terms. However, physicians who violate fraud laws today are subject to more significant penalties than was the case ten to twelve years ago—"[s]ince 1996, the fines and prison sentences for medical doctors have dramatically increased. The amount of the fraud is now tripled plus \$10,000 is added for each instance of overbilling."⁶⁸ This increase in fines has significant implications. Prosecutors often "use the federal . . . sentencing guidelines to intimidate doctors into pleading guilty to felonies and paying huge fines in exchange for a reduced prison sentence."⁶⁹ Based on this data, it appears that physicians who break fraud laws are treated at least comparably to, and arguably more harshly than, those who commit common law fraud.⁷⁰

Moreover, it appears that some physicians are prosecuted for unintentional violations of the law. Physicians, for example, who bill Medicare for lab tests that are not recognized by Medicare, or who bill for a procedure or service using the wrong HCPCS/CPT code,⁷¹ may be deemed to have engaged in a criminal offense.⁷² The absence of intent is not determinative. While the

must use them as a reference. *Booker*, 543 U.S. at 264 ("The district courts, while not bound to apply the Guidelines, must consult those Guidelines and take them into account when sentencing."). Prior to *Booker*, judges were able to depart from the Guidelines only under specified circumstances, most notably when a defendant provided substantial assistance to the prosecution. See LISA M. SEGHELLI & ALISON M. SMITH, CONGRESSIONAL RESEARCH SERVICE, FEDERAL SENTENCING GUIDELINES: BACKGROUND, LEGAL ANALYSIS, AND POLICY OPTIONS, at CRS-15 (2007), available at <http://www.fas.org/sgp/crs/misc/RL32766.pdf>.

68. LIBBY, *supra* note 53, at 25. Violations of the False Claims Act may include criminal prosecution as well as civil and administrative actions and penalties. See 18 U.S.C. §§ 286–287 (2006) (providing for fines and prison sentences of up to five years for fraud against the government and up to ten years for conspiracy to defraud). Often both criminal and civil charges are brought. The statutory fines are designated under the civil provisions of the False Claims Act. See 31 U.S.C. § 3729(a) (2006). The penalties of \$5,000 to \$10,000 per offense have been adjusted upward to account for inflation. See Civil Monetary Policies Inflation Adjustment, 28 C.F.R. § 85.3(9) (2008).

69. LIBBY, *supra* note 53, at 25.

70. Other white-collar fraud committed in the business setting is also subject to harsh penalties. Revisions to the Sentencing Guidelines, including significant increases in prison sentences and fines, for individuals and corporations convicted of white-collar and financial crimes were made in response to a congressional directive in the Sarbanes-Oxley Act. See Stephanos Bibas, *White-Collar Plea Bargaining and Sentencing After Booker*, 47 WM. & MARY L. REV. 721, 726–27 (2005).

71. HCPCS/CPT codes are codes assigned by Medicare and other insurers to each medical service performed by a physician for purposes of uniformity of reimbursement.

72. See, e.g., *United States v. Janati*, No. 05-4255, 2007 WL 2197065, at **1 (4th Cir. Aug. 1, 2007) (physician convicted of criminal fraud for using wrong code for office visits). Correctly coding claims is apparently quite difficult. See Mitchell S. King et al., *Accuracy of CPT Evaluation and Management Coding by Family Physicians*, 14 J. AM. BOARD FAM. MED. 184, 188 (2001) (noting the "substantial" coding error rate in a survey of 600 physicians).

mental state required to find criminal liability under the False Claims Act is a “knowing” violation, i.e., the physician knowingly submitted a false claim,⁷³ the knowledge standard may be satisfied by a showing of “conscious avoidance” of knowledge of the truth or “reckless disregard” for the truth.⁷⁴ In addition, under the False Claims Act, civil penalties may be imposed when a physician “acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.”⁷⁵

Prosecutors, in a number of cases, have stretched the boundaries of “reckless disregard of the truth or falsity of the information” and courts have differed in the interpretation of the phrase, with some equating it with “aggravated gross negligence”⁷⁶ and others requiring something closer to intentional harm. Because it is often difficult to determine whether a physician intentionally submitted a false claim or committed an error, physicians have been criminally charged when they mistakenly submit the wrong billing code for a patient. In a recent case, a federal judge found that the government’s criminal fraud case against a physician was frivolous because the government failed to provide evidence of the defendant’s requisite mental state.⁷⁷ The defendant was awarded nearly \$300,000 in legal fees.⁷⁸ A criminal law professor who worked with the defendant on the case commented that often in these cases “[the government] is just looking at CPT code usage and anybody out on the tail of the distribution is targeted for criminal prosecution” even if there is no evidence of intentional wrongdoing.⁷⁹ Doctors in these cases often

73. See 18 U.S.C. § 287 (providing criminal liability for any claim, or claims, presented to the U.S. Government that is “knowing[ly] . . . false, fictitious, or fraudulent”). Cf. 31 U.S.C. § 3729 (providing civil liability for false claims “knowingly” presented to the government for payment or approval); 18 U.S.C. § 1347 (providing criminal liability for false claims “knowingly” submitted to a health care benefit program).

74. See *United States v. Nazon*, 940 F.2d 255, 258 (7th Cir. 1991) (upholding jury instructions interpreting 18 U.S.C. § 287, which permitted the jurors to “infer knowledge from a combination of suspicion and indifference to the truth” (emphasis omitted)); *United States v. Gold*, 743 F.2d 800, 822 (11th Cir. 1984) (approving the use of a “conscious avoidance” jury instruction in medical fraud case against optician).

75. 31 U.S.C. § 3729(b).

76. See, e.g., *United States v. Krizek*, 111 F.3d 934, 941–42 (D.C. Cir. 1997).

77. See Amy Lynn Sorrel, *Judge Rules Criminal Fraud Case Against Idaho Doctor Is Frivolous*, AM. MED. NEWS, Aug. 20, 2007, <http://www.ama-assn.org/amednews/2007/08/20/gvsb0820.htm>.

78. *Id.*

79. *Id.* (alteration in original) (quoting Jeffrey S. Parker, Professor of Law, George Mason University) (internal quotation marks omitted).

settle “even when they did nothing wrong, because the financial stakes are so high,” and sometimes they face significant jail time.⁸⁰

III. PHYSICIANS WHO BREAK LAWS INVOLVING PATIENT CARE

A second category of laws that physicians break govern clinical practice and patient treatment rather than business-related activities. Examples range from prescribing opioids for chronic pain patients or medical marijuana for cancer patients to helping a terminally ill patient end his or her life.

In the case of physicians who break the law regarding prescribing of opioids, reasons may vary from greed to a desire to appropriately treat their patients' pain. Under the Controlled Substances Act⁸¹ (CSA), to find a physician guilty of criminal violation of the law for prescribing controlled substances, the prosecution must prove that the physician knowingly or intentionally prescribed outside “the usual course of . . . professional practice” or not for a “legitimate medical purpose.”⁸² In some cases, physicians intentionally violate the law by knowingly prescribing without a medical purpose. Generally, the purpose of such prescribing is monetary gain or sexual favors; physicians demand such benefits in exchange for the prescription. The “patient” may need the drug to feed an addiction or may sell it on the street. In these circumstances, law enforcement is ideally swift and harsh.⁸³

On the other hand, physicians may violate the CSA in order to treat their patients. In these cases, they may believe they are complying with the law as they are prescribing for a legitimate medical purpose and within, what they believe, is the usual course of professional practice. Dozens of physicians have been arrested for what they argue is appropriate treatment of chronic pain patients.⁸⁴ An example is Dr. William Hurwitz. Hurwitz, who practiced in northern Virginia, was arrested for prescribing large dosages of opioids that prosecutors alleged were related to several deaths.⁸⁵ Yet, many of his patients asserted that he had greatly improved the quality of their lives, and a number of

80. *Id.* (citing Robert S. Salcido, attorney in Washington, D.C. and former Justice Department civil fraud lawyer); *see also* Rocco DeFrancesco, *Surplus Medicare Fraud Insurance*, PHYSICIAN'S NEWS DIGEST, July 2005, <http://www.physiciansnews.com/finance/705.html>.

81. 21 U.S.C. §§ 801–971 (2006).

82. *See* 21 U.S.C. § 830(b)(3)(A)(ii) (2006); 21 C.F.R. § 1306.04(a) (2008).

83. *See* Hoffmann, *supra* note 4, at 236–38 (providing statistics and description of a number of cases in which physicians have been investigated, arrested, and prosecuted for prescribing controlled substances).

84. *See id.* at 239–56 (describing the cases of Drs. Frank Fisher, Cecil Knox, William Hurwitz, Jeri Hassman, and Ronald McIver).

85. *Id.* at 246.

pain experts described him as a caring physician.⁸⁶ Hurwitz was initially sentenced to twenty-five years in prison, despite the prosecution's argument that he should receive a life sentence.⁸⁷ The sentence was subsequently reduced to fifty-seven months after he successfully appealed the initial conviction on the grounds that the court wrongly "instructed the jury that it could not consider Hurwitz's 'good faith' in his prescribing."⁸⁸

Physicians have also been arrested and prosecuted in California for growing and dispensing marijuana for cancer and HIV patients. California passed the country's first law permitting physicians to "prescribe" marijuana for medical purposes in 1996.⁸⁹ The law, also known as Proposition 215, requires patients who wish to grow or buy marijuana to treat their symptoms to obtain written or oral authorization from their physician.⁹⁰ Such patients and their designated primary care givers are protected from criminal prosecution under California law for obtaining, possessing, or cultivating marijuana for patients' personal medical use. Physicians who comply with the state law, however, can be prosecuted for violation of the federal CSA, which categorizes marijuana as a Schedule I drug that cannot lawfully be prescribed for any reason.⁹¹ According to medical marijuana advocates, an estimated 1500 physicians in California, "mostly oncologists and AIDS specialists," have authorized medical marijuana for a patient.⁹² However, most of the authorizations have been from a small group of about a dozen physicians.⁹³ In 2005, Dr. Mollie Fry was arrested by federal drug agents for growing marijuana and issuing written authorizations to many patients.⁹⁴ Fry, "a cancer survivor who learned about the benefits of medical marijuana while enduring chemotherapy and a double mastectomy,"⁹⁵ set up a practice in a small town in

86. One physician said he was "doing heroic things for his patients." *Id.* at 247 (quoting Dr. James Campbell, Professor of Neurosurgery and Director of the Blaustein Pain Treatment Center at Johns Hopkins University).

87. *Id.* at 249.

88. Hoffmann, *supra* note 4, at 249.

89. California Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West Supp. 2009).

90. *Id.* § 11362.5(d).

91. *See Gonzales v. Raich*, 545 U.S. 1 (2005).

92. Lisa Leff, *Calif. 'Pot Docs' Put Selves at Risk*, WASHINGTONPOST.COM, Nov. 5, 2006, http://washingtonpost.com/wp-dyn/content/article/2006/11/04/AR2006110400516_pf.html.

93. *Id.*

94. Dean E. Murphy, *Arrests Follow Searches in Medical Marijuana Raids*, N.Y. TIMES, June 23, 2005, at A12 (noting that Fry wrote a recommendation for marijuana to an undercover federal agent, which Fry's husband, Dale Schafer, filled).

95. *New Book Exposes the First Federal Trial of a Medical Marijuana Doctor*, MED. MARIJUANA AM., Dec. 4, 2008, <http://www.medicalmarijuanaofamerica.com/content/view/246/110/> (reviewing VANESSA NELSON, COOL MADNESS: THE TRIAL OF DR. MOLLIE FRY AND DALE SCHAFFER (2008)).

northern California “and began recommending medical marijuana to her patients in accordance with state law.”⁹⁶ Under federal law, Fry was able to recommend marijuana use to her patients⁹⁷ but was not able to grow it for her patients or for herself.⁹⁸ Fry believed that she was doing the right thing for her patients and was willing to go to jail for it.⁹⁹ She was sentenced to a five year prison sentence, the minimum sentence based on the volume of marijuana that she had cultivated.¹⁰⁰ Judge Damrell, in sentencing the defendant, stated that he took “no pleasure in imposing [the] sentence,”¹⁰¹ implying that the recommended five-year sentence under the Federal Sentencing Guidelines did not seem appropriate in the case.

In these and other cases involving patient care, physicians may intentionally or knowingly break the law because they believe it is in their patient’s best interest to do so or because such action is consistent with their professional norms. They perceive complying with the law as breaching their duty to their patients as well as violating their autonomy and contravening their judgment as to what is the right thing to do.¹⁰² Their behavior is consistent with

[n]ormative theories of compliance with law [which] hold that people obey the law because they believe it is right to do so. This sense of rightness may arise because the behavior required by the law is consistent with the individual’s own sense of right and wrong, or from a sense that the law is the product of a “legitimate” or fair authority that is entitled to obedience.¹⁰³

96. *Id.*

97. *Conant v. Walters*, 309 F.3d 629 (9th Cir. 2002) (holding that physicians who recommend the use of cannabis to patients as specified under California law are protected by the First Amendment).

98. *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 486 (2001) (holding that there is no medical necessity exception to the CSA’s prohibition against manufacturing and distributing cannabis).

99. See Leff, *supra* note 92 (quoting Fry as saying, “What did I take an oath to do? To do no harm and to alleviate pain and suffering . . . I’m going to be true to my oath, and I’m even willing to go to prison for it.” (internal quotation marks omitted)).

100. *Medical Marijuana: California Dr. Molly [sic] Fry Sentenced to Five Years*, DRUG WAR CHRON., Mar. 28, 2008, http://stopthedrugwar.org/chronicle/529/molly_fry_sentenced_five_years_medical_marijuana.

101. News Release, U.S. Drug Enforcement Admin., California Doctor-Lawyer Couple Get Five Years for Growing and Selling Marijuana (Mar. 20, 2008), <http://www.usdoj.gov/dea/pubs/states/newsrel/sanfran032008.html> (internal quotation marks omitted) (noting the prosecution argued that Fry and her husband sold the marijuana as a money making scheme rather than to treat patients).

102. See Kent Greenawalt, Commentary, *Legal Enforcement of Morality*, 85 J. CRIM. L. & CRIMINOLOGY 710, 718 (1995) (“The most serious breach of someone’s autonomy involves coercion that contravenes that person’s own rational, reflective judgment.”).

103. Zita Lazzarini et al., *Evaluating the Impact of Criminal Laws on HIV Risk Behavior*, 30 J.L. MED. & ETHICS 239, 249 (2002) (citing T. TYLER, *WHY PEOPLE OBEY THE LAW* (1990);

In these cases, physicians are not complying with the law because they disagree normatively with its requirements. Furthermore, they may distrust the government's judgments as to what is in their own interest as well as in their patients' best interest.¹⁰⁴

Physician advocates might label these actions by physicians as "civil disobedience." The American Medical Association (AMA) Code of Medical Ethics actually condones civil disobedience in some circumstances, stating:

Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct. In general, when physicians believe a law is unjust, they should work to change the law. In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations.¹⁰⁵

While some physicians who break the law may engage in "true" civil disobedience, technically, most physicians who break the law do so because they perceive it as bad for their patients, and thus are not engaging in what is more traditionally defined as civil disobedience. In an effort to distinguish civil disobedience from other forms of lawbreaking, Childress constructed a framework for moral analysis of illegal action.¹⁰⁶ He contrasts features of lawbreaking that are more or less morally justifiable.¹⁰⁷ Acts, for example, that are open and public, nonviolent, and justified by higher law or conscience, are generally less morally culpable than those that are clandestine, evasive of law enforcement, and violent.¹⁰⁸ True civil disobedience, according to Childress, is a nonviolent act publicly performed for the purpose of protesting a law or

Tom R. Tyler, *Public Trust and Confidence in Legal Authorities: What Do Majority and Minority Group Members Want from the Law and Legal Institutions?*, 19 BEHAV. SCI. & L. 215 (2001)).

104. See Greenawalt, *supra* note 102, at 719 ("Exactly how much paternalism people will countenance depends on how strongly they rate the value of autonomy and to what degree they trust the judgments of the government as to what is in their self-interests.").

105. AM. MED. ASS'N, CODE OF MEDICAL ETHICS: THE RELATION OF LAW AND ETHICS Op. 1.02; see also Chalmers C. Clark, Letter to the Editor, *Civil Disobedience: The Devil Is in the Details*, HASTINGS CENTER REP., July–Aug. 2005, at 4 (responding to Robert Macauley, *The Hippocratic Underground: Civil Disobedience and Health Care Reform*, HASTINGS CENTER REP., Jan.–Feb. 2005, at 38) ("As a public trust, the medical profession has a lofty responsibility to respect law, but respect for law does not imply slavishness. The higher duty of the profession, according to its social contract, is to the priority of patient benefit. The medical profession is a socially endowed moral autonomy . . . [A]s public trust diminishes, professional autonomy likewise declines. In service of the ongoing need for public persuasion, laws or policies that cut against patient benefit must be strenuously resisted—through proper channels—yet indeed, as last resort, the laws must be broken.").

106. James F. Childress, *Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: A Framework for the Analysis and Assessment of Illegal Actions in Health Care*, 10 J. MED. & PHIL. 63, 65 (1985).

107. *Id.*

108. *Id.*

government policy, where the wrongdoer is willing to undergo arrest and prosecution.¹⁰⁹

Childress distinguished civil disobedience from “conscientious objection” and “evasive noncompliance.”¹¹⁰ Conscientious objection is a refusal to obey based on personal moral beliefs rather than on a belief that the law should be changed—a “moral-political” justification.¹¹¹ Unlike civil disobedience, evasive noncompliance is not done overtly or submissively; it is covert and evasive.¹¹² Physician lawbreaking may fall into any of these three categories depending on its specific elements.

When physicians break law they view as harmful to their patients, the acts are nonviolent but are generally not done openly as doing so would breach patient confidentiality and privacy. In these cases, doctors are violating the law primarily so that they can assist their patients or practice what they think is good medicine. This may be both a matter of conscience and pragmatic. Physicians no doubt disagree with the law they are violating and may think it should be changed, but they may not be engaged in formal actions to change the law. In some cases, physicians do not want to change the law but believe that in a specific case, e.g., euthanasia, the law should not apply. In these cases, Childress would categorize the physician’s actions as conscientious objection.¹¹³ Most physicians, although not all, are not submissive to arrest and punishment; nor are they typically evasive, i.e., they do not run from the law and the illegal acts they perform may be done in the presence of other health care providers. Some physicians may also underestimate the legal risk associated with their actions. Under Childress’s typology of dissent, physicians who break what they believe to be bad law but do not do so openly or submissively, would be committing evasive noncompliance.¹¹⁴

True civil disobedience in health care does occur, although it is relatively rare. For example, the actions of Dr. Jack Kevorkian would appear to meet the traditional definition of civil disobedience. Kevorkian engaged in a nonviolent act (assisting his patients terminate their lives),¹¹⁵ openly and, in at least one

109. See *id.* at 66; see also Matthew R. Hall, *Guilty but Civilly Disobedient: Reconciling Civil Disobedience and the Rule of Law*, 28 CARDOZO L. REV. 2083 (2007) (proposing a doctrinal definition of civil disobedience).

110. Childress, *supra* note 106, at 67–69.

111. *Id.* at 68.

112. *Id.* at 68–69.

113. See *id.* at 68 (defining “conscientious objection” as “public, nonviolent, and submissive violations of law based on personal-moral . . . convictions and intended primarily to witness to those principles or values”).

114. See *id.* at 68–69 (defining “evasive noncompliance” as “illegal action [that] is both covert and evasive”).

115. See Childress, *supra* note 106, at 75 (defining “violence as intentional and unauthorized harm or injury to a person against his/her will,” and noting that “mercy killing,” although an

case, publicly, for the purpose of changing the law regarding physician-assisted suicide.¹¹⁶ Dr. Timothy Quill also, arguably, committed civil disobedience when he published an article in the *New England Journal of Medicine* admitting that he had assisted a patient end her life.¹¹⁷ In the area of reproductive rights, Dr. C. Lee Buxton, a professor at Yale School of Medicine, and Estelle Griswold, then executive director of the Planned Parenthood League of Connecticut, engaged in civil disobedience when they opened a birth control clinic in New Haven, Connecticut, intending to challenge the validity of a Connecticut statute that banned prescribing of oral contraceptives.¹¹⁸

In addition to violation of the laws regarding prescribing controlled substances, i.e., opioids and marijuana, there are a number of cases where physicians have broken or continue to break the law because they view it as harmful to their patients. For example, prior to *Roe v. Wade*,¹¹⁹ there was widespread violation of the laws prohibiting abortion.¹²⁰ In 1955, Planned Parenthood organized a conference on abortion in the United States where conferees speculated that there could be between 200,000 and 1.2 million abortions performed annually.¹²¹ Clearly, it was not an area where many doctors were being prosecuted or feared prosecution.

In these cases, physicians felt compelled to perform “abortions for pregnant women who might otherwise resort to dangerous, back-alley procedures,” and also because they wanted to honor their patient’s self-

intentional act, does not qualify as a violent act unless “it intentionally inflicts a harm or injury on a person against that person’s will”).

116. In a 1998 broadcast of *60 Minutes*, Kevorkian permitted the airing of a videotape showing him assisting Thomas Youk, a fifty-two year old male in the final stages of ALS, end his life. *60 Minutes: Death by Doctor* (CBS television broadcast Nov. 22, 1998), available at http://www.cbsnews.com/video/watch/?id=4462047n%3fsource=search_video.

117. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision-Making*, 324 NEW ENG. J. MED. 691 (1991); see also Lawrence K. Altman, *Doctor Says He Gave Patient Drug to Help Her Commit Suicide*, N.Y. TIMES, Mar. 7, 1991, at A1 (discussing how Dr. Quill “agonized” over the decision to help his patient when she asked him to assist her in ending her life).

118. Ellen Chesler, *Public Triumphs, Private Rights*, MS. MAG., Summer 2005, available at <http://www.msmagazine.com/summer2005/birthcontrol.asp>. Buxton and Griswold were arrested for dispensing contraceptives to a married couple and convicted and fined \$100 each. *Id.* They appealed the conviction. Their case went to the Supreme Court, which determined that the Connecticut law was unconstitutional. See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

119. 410 U.S. 113 (1973).

120. See Childress, *supra* note 106, at 64 (“Birth control and abortion have perhaps been the subjects of most illegal actions by both professionals and lay people over the last century or so [in the area of health care].”).

121. JAMES RISEN & JUDY L. THOMAS, WRATH OF ANGELS: THE AMERICAN ABORTION WAR 10–11 (1998).

determination regarding her desire not to have a child.¹²² Arguably, it was the “ideological and humanitarian impulses of [these] physicians pushing them into law-breaking.”¹²³ The law’s reaction to this lawbreaking was, for the most part, not to prosecute physicians unless the practice came to public attention.¹²⁴ Yet, many physicians were uncomfortable with the criminalization of the procedure, and physicians as a group became involved in the effort to change the law.¹²⁵

An additional example where physicians may break the law because they believe it is harmful to their patients is when laws and regulations mandate aggressive treatment of severely disabled infants with life threatening conditions even when the parents have requested termination or withholding of such treatment. These laws include the Child Abuse Prevention and Treatment Act¹²⁶ (CAPTA) and its accompanying regulations (also known as the “Baby

122. See Michael L. Gross, *Physician-Assisted Draft Evasion: Civil Disobedience, Medicine, and War*, 14 CAMBRIDGE Q. HEALTHCARE ETHICS 444, 448 (2005). Abortions were often performed by non-physicians, primarily “midwives and herbalists.” Jesilow et al., *supra* note 1, at 156.

123. Jesilow et al., *supra* note 1, at 157. While many physicians had altruistic goals in helping women who requested an abortion, it is also true that physicians were behind the early efforts to criminalize it, in large part to prevent abortions by competitors, i.e., lay abortionists. *Id.* at 156.

124. See Samuel W. Buell, Note, *Criminal Abortion Revisited*, 66 N.Y.U. L. REV. 1774, 1789–90 (1991) (citing J. BATES & E. ZAWADZKI, CRIMINAL ABORTION 35–75 (1964)) (stating that there were few abortion convictions because the effort required of law enforcement was not justified in light of the ambivalent attitude toward the laws). The literature indicates that the few prosecutions that were performed “targeted notorious or unusually large abortion ‘rings’ or ‘mills’; legitimate doctors were rarely prosecuted. *Id.* at 1790; see also Daniel G. Wyllie, Comment, *Abortion Reform in Michigan—An Analysis of the Proposed Code’s Provisions*, 14 WAYNE L. REV. 1006 (1968).

125. Dr. Alan Guttmacher, an outspoken obstetrician for the legalization of abortion, sat in on meetings of the American Law Institute (ALI), pushing them to write model legislation that would decriminalize abortion. RISEN & THOMAS, *supra* note 121, at 11. Subsequently the AMA endorsed the ALI plan (although it only allowed abortion to preserve the life or health of the mother or in cases of rape, incest, or severe fetal abnormalities). *Id.*

126. Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (1974) (codified as amended at 42 U.S.C. §§ 5101–5116i (2000 & Supp. IV 2007)). CAPTA provides that as a condition of receipt of funds for child abuse prevention and treatment programs, states must incorporate within their definition of medical neglect the failure to provide life sustaining treatment to severely disabled newborns except in very limited circumstances. 42 U.S.C. § 5106a(b)(2)(B); see 45 C.F.R. § 1340.15 app. (2007) (giving “interpretive guidelines” regarding allowable exceptions to “medically indicated treatment” of disabled infants). Failure to incorporate the definition means that states are denied federal funds for these programs. 42 U.S.C. § 5106a(b)(2)(B). Where states have incorporated the federal definition of medical neglect into their own definition, physicians could be prosecuted for failure to report the case to child protective services, or for manslaughter or criminal negligence for failure to treat when they

Doe Rules”), and the Born-Alive Infants Protection Act of 2002¹²⁷ (BAIPA). In cases involving treatment of severely disabled newborns, physicians may break the rules because (1) they believe it is not in the infant’s best interest to continue treatment, but rather that it perpetuates the infant’s suffering, and (2) because it deprives the child’s parents of the right to make treatment decisions for the child. While physicians may violate the law by failing to treat these infants, this is also an area where law enforcement agents do not seem to prosecute physicians.¹²⁸ Despite such lack of enforcement, there was speculation a few years ago that physicians who failed to adequately treat newborns might be new targets of prosecutors. In April 2005, DHHS announced it would be investigating all circumstances where an individual or entity was reported to be withholding medical care from an infant born alive in potential violation of federal statutes (specifically, BAIPA).¹²⁹ DHHS also instructed state child protective service agencies that are responsible for implementing regulations to enforce the 1984 Baby Doe Rules and to insist on local execution of legal remedies to prevent non-treatment decisions deemed impermissible by the Baby Doe Rules.¹³⁰ Some argued that this directive signaled an end to a period of benign regulatory neglect in this area,¹³¹ yet cases of physicians arrested for violation of these laws have not surfaced.

In addition to physician-assisted suicide, distribution of contraceptives, abortion, treatment of seriously disabled newborns, reporting of child abuse

know that such failure would lead to serious harm or to the death of the child. See *id.* § 5106a(b)(2)(B)(ii)–(iii).

127. Born-Alive Infants Protection Act of 2002, Pub. L. No. 107-207, 116 Stat. 926 (codified as amended at 1 U.S.C. § 8 (2006)). BAIPA provides that a viable infant that is born alive must be treated as a person under the law. *Id.*

128. Irene Hurst, Letters to the Editor, *First Rule: Choose Your Battles Wisely*, 116 PEDIATRICS 288 (2005) (stating that “no state has prosecuted a single doctor, nurse, medical institution, or family under these regulations”).

129. ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP’T OF HEALTH & HUMAN SERVS., LOG. NO. ACYF-CB-PI-05-01, PROGRAM INSTRUCTIONS (2005); see Ceci Connolly, *Doctors Are Warned on Fetus Care: Guidelines Are Issued on Born-Alive Infants Protection Act*, WASH. POST, Apr. 23, 2005, at A7.

130. See Laura Hermer, *The “Born-Alive Infants Protection Act” and Its Potential Impact on Medical Care and Practice*, HEALTH L. PERSP., Sept. 27, 2006, available at [http://www.law.uh.edu/healthlaw/perspectives/2006/\(LH\)BAIPA.pdf](http://www.law.uh.edu/healthlaw/perspectives/2006/(LH)BAIPA.pdf) (“Because of the clear connection the CAPTA memorandum makes between the failure to provide medical treatment and state child abuse and neglect laws, it appears that physicians and hospitals may be subject to a criminal charge of abuse and neglect should they withhold medical care from premature and/or disabled infants.”).

131. See Sadath A. Sayeed, *Baby Doe Redux? The Department of Health and Human Services and the Born-Alive Infants Protection Act of 2002: A Cautionary Note on Normative Neonatal Practice*, 116 PEDIATRICS e576, e577 (2005) (“[T]he current administration’s resurrection of recently quiescent oversight of the treatment of imperiled newborns agitates the legal fault line that physicians walk along when caring for these infants.”).

and neglect, and dispensing of marijuana, physicians may also exercise “civil disobedience” in order to protect patients or to act consistently with their ethical norms by performing involuntary euthanasia, terminating treatment when they deem it futile, or handing out clean needles to addicts to prevent the spread of HIV. These issues raise profound questions about how the law should react to violations of what the violators call “bad law” and how we should assess such laws.

IV. RESPONSE OF LAW ENFORCEMENT TO PHYSICIANS WHO VIOLATE LAWS RELATING TO PATIENT CARE

The response of law enforcement to physicians who violate the law because they claim it harms their patients ranges from seemingly conscious disregard for the impact of their actions on patient care and the relevant medical evidence, to wise inaction. In several cases involving patient care, prosecutors, arguably, do not appropriately exercise their discretion and target physicians who are providing a needed service to a population that finds it difficult to obtain care. This appeared to be the case in the arrest and prosecution of Dr. Frank Fisher.¹³² Fisher, who graduated from Harvard Medical School, operated a clinic in northern California where he served a large Medi-Cal¹³³ population.¹³⁴ He had a history of working with indigent clients and in underserved communities, including on Native American reservations.¹³⁵ In California, approximately 5%–10% of his 3,000 patients “suffered from severe, chronic intractable pain.”¹³⁶ He was charged with five counts of first degree murder stemming from his prescribing of opioids.¹³⁷ At least three of the murder charges appeared entirely bogus. “For example, one of the patients for whom he prescribed opioids died as a passenger in an automobile accident. Another death occurred when a non-patient stole and overdosed on medications that Fisher had prescribed to a patient.”¹³⁸ A third patient actually died while Fisher was in jail and she was unable to obtain her medications.¹³⁹ The murder and drug diversion charges against Fisher were all subsequently dismissed or dropped, but not until after he served five months in

132. Hoffmann, *supra* note 4, at 239–42 (discussing Fisher’s arrest, prosecution, and the consequent effects on his practice of medicine).

133. In California, the Medicaid program is referred to as Medi-Cal. *See* Medi-Cal: Provider Homepage, <http://www.medi-cal.ca.gov/> (last visited May 19, 2009).

134. Hoffmann, *supra* note 4, at 239.

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.* at 240 (footnote omitted).

139. Hoffmann, *supra* note 4, at 240.

prison awaiting a preliminary hearing.¹⁴⁰ The arrests and prosecutions of other pain physicians have also left their patients without adequate pain treatment.

Once law enforcement agents decide to arrest a physician, their tactics may also be unnecessarily dramatic and fear-inducing. Often physicians are arrested in front of their patients. This has been the case for numerous physicians arrested for prescribing opioids to their patients. In the case of Fisher, for example, “over twenty armed law enforcement agents stormed into Fisher’s clinic and arrested him.”¹⁴¹ Similarly, “more than a dozen federal agents burst into [Dr. Cecil] Knox’s office with guns drawn while he was seeing patients and arrested him. He was taken away in handcuffs and leg irons.”¹⁴² Federal officials also “marched into Dr. Jeri Hassman’s office while she was treating a patient, ‘took off her jewelry, put her in handcuffs and led her to jail.’”¹⁴³

In the case of physicians prescribing opioids for pain patients, law enforcement agents may also pose as patients, attempting to trick the doctor into inappropriately prescribing. Prosecutors have also engaged in questionable trial tactics. During the trial of Dr. William Hurwitz, six past presidents of the American Pain Society sent a letter to Hurwitz’s lawyer citing “‘misrepresentations’ by one of the Justice Department’s expert witnesses.”¹⁴⁴ In the case of Dr. Robert Weitzel, a physician arrested for murder of four severely ill elderly nursing home patients who allegedly died under his care because he gave them opioid analgesics to manage their pain and dyspnea, the prosecution withheld exculpatory evidence—testimony by a palliative care expert that Weitzel did not engage in any criminal wrongdoing.¹⁴⁵ The judge referred to the prosecution’s behavior as “contraven[ing] manifest constitutional, legal, and ethical duties.”¹⁴⁶

Sentencing in these cases can also seem harsh. In fact, in some cases, the judge appears constrained by the Federal Sentencing Guidelines and would have preferred a more compassionate response. In the prosecution of Dr. Mollie Fry, for authorizing marijuana and growing marijuana for use by her patients, herself, and her husband, the judge described the five-year minimum sentence as a “‘tragedy’ that should ‘never have happened.’”¹⁴⁷ Perhaps

140. *Id.*

141. *Id.* at 239.

142. *Id.* at 242 (footnote omitted).

143. *Id.* at 250 (quoting Marc Kaufman, *Worried Pain Doctors Decry Prosecutions*, WASH. POST, Dec. 29, 2003, at A1).

144. Hoffmann, *supra* note 4, at 248–49, 248 n.123.

145. See Kollas et al., *supra* note 8, at 235.

146. *Id.* (internal quotation marks omitted).

147. *Fry and Shafer Released on Bail Pending Appeal*, INDYBAY, Mar. 31, 2007, <http://www.indybay.org/newsitems/2008/03/31/18489777.php> (quoting U.S. District Court Judge

because of the judge's sympathy for Fry, he subsequently granted her release on bail, stating that Fry (and her husband) had "substantial" grounds for appeal that justified their release on bail, including "entrapment, the defendants' state of mind, and the conflict between state and federal laws."¹⁴⁸

In contrast to these cases, where the law enforcement response seems to have ignored claims of patient well-being and been overly harsh, the legal system has responded much more discriminately, even compassionately in a number of cases where physicians appear to be acting to help their patients. This seems to have been the response in the early abortion and contraceptive cases, where law enforcement rarely prosecuted physicians or, if they did so, only for the most blatant of violations. Similarly, it seems to characterize the system's current lack of aggressive enforcement of the Baby Doe Rules despite the passage of the BAIPA and recent pronouncements of DHHS.

The latter, more tepid, response may be especially true when the law is in flux or when there is considerable societal ambivalence about a law. This may explain the legal system's response to the cases of Dr. Jack Kevorkian and Dr. Timothy Quill. Kevorkian assisted over 100 individuals end their lives.¹⁴⁹ Between 1990 and 1999 he was arrested and prosecuted numerous times, all unsuccessfully, until the case of Thomas Youk in 1999.¹⁵⁰ In 1990 and 1992 Kevorkian was indicted for murder in the death of three individuals; however, the cases were dismissed because Michigan had no law against assisting suicide and he had "merely" helped the individuals end their own lives with his "suicide machine."¹⁵¹ After these unsuccessful prosecutions, the Michigan legislature hurried to pass a fifteen-month ban on assisted suicide.¹⁵²

Frank Damrell); *see also* *New Book Exposes the First Federal Trial of a Medical Marijuana Doctor*, *supra* note 95 (discussing the circumstances leading to Fry's arrest).

148. *Fry and Shafer Released on Bail Pending Appeal*, *supra* note 147.

149. Monica Davey, *Kevorkian Freed After Years in Prison for Aiding Suicide*, N.Y. TIMES, June 2, 2007, at A8.

150. *People v. Kevorkian*, 639 N.W.2d 291 (Mich. Ct. App. 2001) (affirming Kevorkian's conviction for second degree murder and delivery of controlled substances); *see* Frontline: The Kevorkian Verdict: Chronology, <http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html> (last visited May 20, 2009).

151. *See People v. Kevorkian*, Nos. CR-92-111590-FC, 92-DA-5303-AR, 1992 WL 12597834 (Mich. Cir. Ct. July 21, 1992) (finding that "physician assisted suicide was not a crime in Michigan," thus dismissing the charges of open murder brought against Kevorkian in 1992 for assisting in the suicides of Marjorie Wantz and Sherry Miller); William E. Schmidt, *Prosecutors Drop Criminal Case Against Doctor Involved in Suicide*, N.Y. TIMES, Dec. 15, 1990, at 10 (noting that the Michigan district court dismissed murder charges brought against Kevorkian for assisting Jane Adkins commit suicide in 1990 and "[d]eclar[ed] that the debate over euthanasia and suicide must be sorted out by the state lawmakers rather than" the courts); *see also* Frontline: The Kevorkian Verdict: Chronology, *supra* note 150.

152. MICH. COMP. LAWS SERV. §§ 752.1021-.1027 (LEXISNEXIS 2001); *see also* Frontline: The Kevorkian Verdict: Chronology, *supra* note 150 (noting passage of assisted suicide ban).

Kevorkian violated the ban several times, but there was some uncertainty about the ban's constitutionality,¹⁵³ and a jury found him not guilty of violating the ban although he admitted to assisting a suicide during the fifteen-month period. Subsequently, the state's court of appeals found the ban unconstitutional for "technical" reasons, but shortly thereafter the Michigan Supreme Court reversed the court of appeals decision.¹⁵⁴ The supreme court also declared that a statutory ban was not necessary to prosecute an individual for assisted suicide; under the common law, assisted suicide could be prosecuted as a felony with a five-year prison term.¹⁵⁵ Despite this declaration, Michigan juries on three occasions acquitted Kevorkian in subsequent prosecutions for assisted suicide.¹⁵⁶ During this period, many viewed Kevorkian as a hero, helping the cause of physician-assisted dying.¹⁵⁷ It was not until 1999 when Kevorkian was tried for the first degree murder of Thomas Youk that he was found guilty.¹⁵⁸ The Youk case, however, was different from the prior cases in that Youk, who had Lou Gehrig's disease, was unable to trigger his own death, and Kevorkian directly injected him with a lethal drug.¹⁵⁹ The act was also televised on *60 Minutes*.¹⁶⁰ The jury ultimately found Kevorkian guilty of

153. A judge in Wayne County determined the law to be unconstitutional, but an Oakland County prosecutor said the ruling was not binding in his jurisdiction. *Suicide Law Struck Down, but Kevorkian Stays Jailed*, N.Y. TIMES, Dec. 14, 1993, at A18; see generally *Hobbins v. Att'y Gen.*, 518 N.W.2d 487 (Mich. Ct. App. 1994) (discussing procedural histories of appeals that it consolidated from the Wayne and Oakland circuit courts regarding the constitutionality of the assisted suicide ban), *rev'd* *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994).

154. *Hobbins*, 518 N.W.2d at 491 (holding the legislation criminalizing assisted suicide constitutionally infirm because it contained "two distinct objects"), *rev'd*, *Kevorkian*, 527 N.W.2d 714.

155. *Kevorkian*, 527 N.W.2d at 739 ("[E]ven absent a statute that specifically proscribes assisted suicide, prosecution and punishment for assisting in a suicide would not be precluded. Rather, such conduct may be prosecuted as a separate common-law offense . . .").

156. See Frontline: *The Kevorkian Verdict: Chronology*, *supra* note 150 (noting the three instances in which Michigan juries acquitted Kevorkian on charges brought against him under the state's assisted suicide ban, including May 2, 1994 for the death of Thomas Hyde; March 8, 1996 for two separate deaths; and April 1, 1996 for the deaths of Marjorie Wantz and Sherry Miller); *Newshour: CBS' Assisted Suicide Decision* (PBS television broadcast Nov. 24, 1998), *transcript available at* http://www.pbs.org/newshour/bb/media/july-dec98/suicide_11-24.html (referencing interview between CBS's Mike Wallace and Jack Kevorkian); see e.g., David Margolick, *Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide*, N.Y. TIMES, May 3, 1994, at A20 (discussing Michigan's assisted suicide ban in light of Kevorkian's acquittal of charges brought against him for assisting Thomas Hyde commit suicide).

157. See Michael Betzold, *The Selling of Doctor Death: How Jack Kevorkian Became a National Hero*, NEW REPUBLIC, May 26, 1997, at 22.

158. See *People v. Kevorkian*, 639 N.W.2d 291, 296 (Mich. Ct. App. 2001).

159. See *id.*

160. See *60 Minutes: Death by Doctor*, *supra* note 116; see also *Kevorkian*, 639 N.W.2d at 296 (noting that the videotapes of Kevorkian administering lethal drugs to Youk, which were aired on *60 Minutes*, were shown to the jury during trial).

second degree murder and the judge sentenced him to ten to twenty-five years in prison.¹⁶¹ In her sentencing statement, Judge Jessica Cooper was undoubtedly influenced by Kevorkian's blatant disregard for the law stating: "[Y]ou had the audacity to go on national television, show the world what you did and dare the legal system to stop you. Well, sir, consider yourself stopped."¹⁶²

The response of the criminal justice system to the public disclosure by Dr. Timothy Quill that he had assisted one of his patients who suffered from leukemia end her life, was clearly one of compassion.¹⁶³ In an article in the *New England Journal of Medicine*,¹⁶⁴ Quill stated that he prescribed the patient, a forty-five-year old woman, "with enough barbiturates . . . to commit suicide when and if the time came . . . [He] made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide."¹⁶⁵ The prosecutor brought the case before a grand jury, seeking a criminal indictment. The grand jury, clearly sympathetic to the plight of the patient, declined to indict Quill on criminal charges.¹⁶⁶

As demonstrated by these cases and others, there are a number of ways in which the criminal justice system may respond to physician lawbreaking when society is strongly divided about the correctness of the law. Prosecutors may give low priority to enforcement, or, as in the case of Quill, a grand jury may decline to issue an indictment.¹⁶⁷ If the case goes to court, juries are often sympathetic to physicians when they are performing what is perceived as a merciful act. In many cases, such as those of Kevorkian, where a physician has been prosecuted for physician-assisted suicide or euthanasia, he or she has been acquitted.¹⁶⁸ In some cases, this may be a result of jury nullification. When a physician is found guilty, judges may have some discretion in how they sentence physicians accused of these kinds of crimes and may be more

161. Kevorkian, 639 N.W.2d at 296.

162. *Statement from Judge to Kevorkian*, N.Y. TIMES, Apr. 14, 1999, at A23.

163. See *supra* text accompanying note 117.

164. Quill, *supra* note 117.

165. *Id.* at 693; see also Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1 (discussing Quill's indictment by a grand jury for charges brought against him related to his role in his patient's suicide).

166. See Altman, *supra* note 165.

167. See also Kollas et al., *supra* note 8, at 235–36 (discussing *Louisiana v. Pou*, in which the Louisiana Attorney General was unable to obtain a grand jury indictment against Dr. Anna Pou, who allegedly euthanized four patients who could not be evacuated from a health care facility after Hurricane Katrina struck New Orleans).

168. See, e.g., David J. Garrow, *Letting the Public Decide About Assisted Suicide*, N.Y. TIMES, June 29, 1997, at E4 (describing the acquittal of Dr. Ernesto Pinzon-Reyes on charges of "hastening the death of a terminally ill cancer patient"); Ronald J. Hansen, *Kevorkian Released from Prison After 8 Years*, DETROIT NEWS, June 2, 2007, at 1 (noting that Kevorkian had been acquitted in several cases of assisted suicide, until he represented himself in court).

lenient when societal views about the issue are strongly divided. The various points in the process offer a set of safety valves to put the brakes on a system that might otherwise be too quick to lump all accused in the same category.

Prosecutor reluctance to enforce or charge and jury reluctance to convict may stem from two problems with the relevant laws: the lack of a consensus as to their moral validity and to their medical justification. Often, these laws have a moral basis and there is not agreement among the profession or across society as to whether the prohibited actions are wrong as a normative matter. While some legal enforcement of morality may be uncontroversial—when the law requires some to refrain from acts that “others” think are immoral, but the target of the law does not—compliance may be limited.¹⁶⁹ This may be especially true when the moral judgments are religiously based.¹⁷⁰

Additionally, these laws are medically questionable. There is often disagreement within the profession as to what is medically appropriate in some of these cases, e.g., physicians may not agree on what is the appropriate dosage of opioids to prescribe to a chronic pain patient; what treatment is in the best interest of a severely impaired and premature newborn; when medical care is truly futile; or whether physician-assisted suicide is justified. Different views within the profession prevent establishment of a unified standard of care and make arguments to harshly treat these physicians more difficult.¹⁷¹

V. OBSERVATIONS, SUGGESTIONS, AND CONCLUSION

The ways in which physicians respond to the law affirm David Mechanic’s observation that medicine has its share of angels *and* scoundrels; yet it is not always clear in which group they belong. For those physicians who break the law, the reasons for their actions will no doubt affect our assessment. When greed is the motivation, we want to condemn physicians for their actions and punish them harshly. In the case of violation of the fraud laws, these doctors appear to view themselves as “above the law” and, as Professor Johnson suggests, to push the boundaries of safe harbors.¹⁷² These physicians may also lack the sensitivity to either the legal or extra-legal sanctions that accompany lawbreaking and do not see breaking these laws as being in conflict with their professional identity. They often view the laws as unfair and feel their actions are justified in order to receive “appropriate” compensation for their work.

169. See Greenawalt, *supra* note 102, at 710 (“[M]uch legal enforcement of morality is uncontroversial and rarely discussed.”).

170. *Id.*

171. See Kollas et al., *supra* note 8, at 233 (finding that “divergent views of the standard of care” were a feature of the five cases they reviewed in which physicians were criminally prosecuted in conjunction with palliative or end of life care).

172. Johnson, *supra* note 2, at 1019 (“There is some sense that doctors are willing to push the envelope on the financial side . . . and are less willing to do that . . . in their clinical decisions.”).

Yet, there are other physicians for whom greed is not the basis of their violation of the fraud laws. In some cases, they believe the insurance rules are harmful to their patients, in others, their violation of the law is not intentional; it is due to negligence and ignorance of the law. Similarly, when physicians violate the CSA because they are prescribing opioids for chronic pain patients, in some cases the motivation may be greed, but often it is because they are trying to treat their patients' pain. In the latter case, they may not know they are breaking the law or they may disagree with the law, believing that their prescribing is appropriate. In many of these cases, as well as some fraud cases, the government response appears overly zealous and lacks judicious discretion. However, in cases where the motivation for the physician's action is clearly not greed but is patient care, the legal response varies from wise inaction to disregard of relevant medical evidence.

In this section, based on the reasons that physicians appear to violate both the fraud laws and laws regarding patient care, as well as observations about how our law enforcement system reacts to this physician behavior, I make a series of suggestions. These suggestions are geared toward improving physician compliance with the law and improving the quality of patient care.

A. *Need for Law Enforcement to Consider Impact on Patients*

In exercising its discretion to pursue physicians for alleged wrongdoing, law enforcement appears to ignore the impact of its actions on patient care. Failure to take this factor into account is misguided. The impact assessment should begin with some consideration of the trauma caused to patients by law enforcement personnel who barge into physicians' offices to arrest them while they are seeing patients, with guns drawn, and in SWAT team attire.¹⁷³ Such dramatic and strong-arm tactics seem wholly unnecessary and are likely harmful to the innocent patients who are forced to witness them.

Moreover, law enforcement should consider how arrest and prosecution of physicians may affect patient access to health care. Doctors who are arrested and prosecuted for fraud or inappropriate prescribing not only face possible jail time and fines but are also likely to lose their licenses, staff privileges, or both. Effectively, they are lost from the numbers of physicians available to treat patients. The little data that is available seems to indicate that often the physicians who are targeted for arrest by prosecutors for fraud are working in

173. See, e.g., Hoffmann, *supra* note 4, at 242 (discussing the arrest of Dr. Cecil Knox based on various charges related to his prescribing of narcotics) (citing Maia Szalavitz, *Dr. Feelscared: Drug Warriors Put the Fear of Prosecution in Physicians Who Dare to Treat Pain*, REASON, Aug. 2004, at 32); see also *supra* text accompanying notes 142–43.

underserved areas or with underserved populations.¹⁷⁴ Taking these physicians out of circulation may mean that their patients lack access to a licensed physician, except in a medical emergency.

These arrests and prosecutions may also have a chilling effect on the behavior of other physicians.¹⁷⁵ A national survey of 331 doctors conducted by the Association of American Physicians and Surgeons (AAPS) in July 1999, regarding the impact of Medicare regulations and the increased government crackdown on fraudulent billing, revealed that “[i]ncreased fear of prosecution or government retaliation has had a negative impact on patients’ access to doctors and their ability to receive certain services such as surgery.”¹⁷⁶ Over 80% reported “increased fear of prosecution or investigation in the prior three years”; 71% “reported making changes in their practice to avoid the threat of prosecution, including greatly restricting services.”¹⁷⁷ More than one-third (34%) of all physician respondents had restricted services, such as surgery, to Medicare patients.¹⁷⁸ Almost one-fourth (23%) said they were not accepting new Medicare patients, and reported that the desire to avoid unpleasant or even threatening encounters with Medicare was a reason for this change in practice pattern.¹⁷⁹ Respondents also complained that compliance with Medicare regulations took a significant amount of their time away from patient care.¹⁸⁰

In addition, the arrest and prosecution of physicians for prescribing opioids has had far-reaching impacts on the treatment of chronic pain patients. Due to the limited number of physicians willing to treat this patient population, these prosecutions have made it more difficult, in some cases impossible, for chronic pain patients to find physicians who will treat them.¹⁸¹

B. Complexity/Legitimacy of Laws

The fact that such a large number of physicians are being arrested and prosecuted for fraud and prescription drug violations raises the possibility of

174. See Dayna Bowen Matthew, *An Economic Model to Analyze the Impact of False Claims Act Cases on Access to Healthcare for the Elderly, Disabled, Rural and Inner-City Poor*, 27 AM. J.L. & MED. 439, 462–66 (2001).

175. See generally *id.* (discussing the “chilling effect” in terms of physician behavior that results from the uncertainty or inability to predict which behavior will lead to false certification prosecutions).

176. See Press Release, Ass’n of Am. Physicians & Surgeons, Doctors’ Study: Medicare “Fraud” Crackdown Hurts Patients (Feb. 4, 2000), available at <http://aapsonline.org/press/medspr.htm>.

177. *Id.*

178. *Id.*

179. *Id.*

180. See *id.*

181. See Hoffmann, *supra* note 4, at 235.

overreaching on the part of prosecutors, and should raise red-flags for those of us concerned about the legitimacy of the rules *and* their enforcement, as well as their impact on patient care and the health care system.

Physicians who violate the fraud laws, in some cases, may have been motivated by their moral evaluation of the act, i.e., they may not have viewed their behavior as wrong or they may have viewed the law as unfair. The literature lends support to this interpretation of the behavior of physicians who intentionally break the fraud laws.¹⁸² Both physicians and medical students were more likely to blame the Medicare and Medicaid billing rules for physician arrests and prosecutions than the actions of the physicians.¹⁸³

The literature on white-collar crime acknowledges that one's moral beliefs, independent of considerations of costs and benefits, can constrain illegal behavior.¹⁸⁴ But, perhaps equally likely, moral beliefs may lead to illegal behavior if the law is deemed to be unfair or unjust. In those circumstances, the response of the criminal justice system is typically to increase sanctions in order to ensure compliance. Over the last decade in fact, the sanctions for violation of the fraud laws have been significantly increased.¹⁸⁵ Another route, however, could be to either persuade physicians that the Medicare and Medicaid billing procedures are fair or to change them so that they are fairer.

Physician reaction to the fraud laws stems largely from the complexity of the billing rules for Medicare and Medicaid. Thus, this may be a starting point for reform. In Japan, the perceived unfairness of the medical insurance reimbursement system led to widespread fraud but the government, understanding the flaws of the system, elected not to aggressively prosecute physicians who violated the rules.¹⁸⁶ In the United States, we have a reimbursement system that is perceived as unfair yet it is aggressively enforced. The two in combination seem especially misguided and suggest the need to simplify or rework the Medicare and Medicaid rules for billing and fraud control and, or at least until that occurs, adopt a less aggressive enforcement policy.

Physician complaints about laws stem from concerns not only about the fairness of the laws but also about the fairness of their enforcement. In the

182. See Raymond Paternoster & Sally Simpson, *Sanction Threats and Appeals to Morality: Testing a Rational Choice Model of Corporate Crime*, 30 LAW & SOC'Y REV. 549, 579 (1996) (finding that white-collar criminals use a utilitarian calculation when deciding to break the law but include in that calculation their moral assessment of the law).

183. See Keenan et al., *supra* note 37, at 170–71.

184. Paternoster & Simpson, *supra* note 182, at 554.

185. See *supra* text accompanying notes 50–56.

186. See Ames Gross & Gayatri B. Koolwal, *Patient Disclosure Rights in Japan's Healthcare System*, PAC. BRIDGE MED., Mar. 1998, http://www.pacificbridgemedical.com/publications/japan/1998_patient_disclosure_rights_in_japans.htm (noting that the “Japanese are loathe to use [legal] means” to improve the quality of patient care).

fraud area, there are numerous anecdotes about physicians who have been criminally prosecuted for relatively minor infractions, i.e., less than a few hundred dollars of overbilling.¹⁸⁷ In some cases, the sanctions also seem largely incommensurate with the violation. Moreover, at least early in the program's history, numerous financial incentives existed for law enforcement agents to arrest and prosecute physicians for fraud violations.¹⁸⁸ These allegations and facts contribute to a perception that the entire fraud enforcement system is unfair and threatens the overall legitimacy of the fraud control effort. Professor William Sage has observed that the focus of the fraud laws on protecting the financial integrity of the Medicare and Medicaid systems rather than patient welfare "tends to breed cynicism among physicians and brings fraud enforcement into conflict with sound health policy."¹⁸⁹ Others have warned that more aggressive law enforcement initiatives "could threaten the long-term political support that is essential to sustaining [fraud control] efforts and might upset the balance between effective fraud control and the burden of compliance."¹⁹⁰

C. *Turning Negligence into Crime*

An additional observation that surfaces after reviewing the cases in which physicians "break the law" is the broad reach of the law to include unintentional violations. There is general agreement that someone who intentionally or knowingly breaks a good law should be prosecuted and punished. However, when the violation of the law is unknowing or unintentional,¹⁹¹ criminal sanctions may not be appropriate as applied to

187. See LIBBY, *supra* note 53, at 32. For example, Libby notes that "[d]uring Richard Kusserow's tenure as [Inspector General of DHHS] from 1981 to 1992, he inaugurated a veritable reign of terror against physicians and other providers. [He] encouraged trivial and malicious prosecutions of doctors for alleged fraud of less than a hundred dollars." *Id.* Libby also provides examples of similarly aggressive prosecutions by state Medicaid Fraud Control Units (FCU). He cites the Hawaii FCU, under the direction of George Yamamoto, which "prosecuted an optician who was convicted of a criminal felony for overbilling Medicaid by \$7.75." *Id.* at 34.

188. Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 246 (2004) (describing funding and incentives in fraud control).

189. William M. Sage, *Fraud and Abuse Law*, 282 JAMA 1179, 1180 (1999). Sage refers to "burdensome coding requirements for evaluation and management [that] continue the unfortunate transformation of the medical record from a clinical management tool into a defensive document." *Id.*

190. ROBERT BERENSON ET AL., AARP PUB. POLICY INST., COST CONTAINMENT IN MEDICARE: A REVIEW OF WHAT WORKS AND WHAT DOESN'T 61 (2008), available at http://assets.aarp.org/rgcenter/health/2008_18_medicare.pdf.

191. The Model Penal Code includes intentional, knowing, reckless, and negligent as mental states that may be sufficient to establish criminal intent. MODEL PENAL CODE § 2.02(2)(a)–(d) (1962).

physicians, despite the fact that the law may allow for it. In these cases, the law may be overly broad, permitting criminal prosecution for negligence.

As regards the fraud laws, it is difficult to know whether physicians intentionally or knowingly violate the law, but it appears that in some cases physicians are being arrested, prosecuted, and threatened with criminal sanctions for technical, or regulatory, violations. Given the multitude and complexity of rules governing Medicare and Medicaid billing, it is possible that in some cases physicians are not intentionally violating the law but are making mistakes in their billing practices. Again, prosecutions for such actions raise concerns about fairness and legitimacy. Rosenzweig argues that as we expand what constitutes criminal wrongs “to include trivial matters more suitably treated as civil wrongs, those who act in good faith yet get caught by the arbitrary exercise of governmental authority perceive themselves as victims of an over-zealous regulatory state that trivializes crime . . . and erodes its moral footing.”¹⁹² Certainly, an argument can be made that such violations should not be subject to criminal prosecution at all, but if they are, sanctions for those who unintentionally commit these technical violations should be less severe than for those where intentionality is clear.¹⁹³

In addition to the arrests and prosecutions of physicians for fraud, scores of physicians are being arrested and prosecuted for drug abuse and diversion based on a standard that is “uncomfortably close” to a civil malpractice standard.¹⁹⁴ The standard has led to the conviction of numerous physicians who were prescribing large volumes of scheduled drugs, e.g., opioids, and treating a large number of chronic pain patients. In many of these cases, there was no evidence that the physicians benefited financially from their prescribing (other than for the office visit). Moreover, “experts disputed the ‘reasonableness’ of the physician’s prescribing practices; and . . . the physician’s patients often included drug addicts who lied to the physician to obtain their drugs.”¹⁹⁵

In addition, under the CSA, while the statutory language for criminal liability requires that a physician knowingly violate the law,¹⁹⁶ the courts have eroded that requirement in a way that is arguably harmful to patients. As in the cases of fraud, “[b]ecause determining what the physician actually knew or intended is difficult, ‘courts have held that a deliberate course of conduct whereby the defendant avoids the requisite guilty knowledge may be held

192. Rosenzweig Testimony, *supra* note 62, at 145.

193. *See id.* at 152–53.

194. Under the CSA, a physician is guilty of criminal conduct if he or she prescribes without a “legitimate medical purpose” and outside “the usual course of his professional practice.” 21 C.F.R. § 1306.04(a) (2008); *see supra* text accompanying notes 76–82.

195. Hoffmann, *supra* note 4, at 239.

196. *See supra* text accompanying notes 76–82.

tantamount to guilty knowledge per se.”¹⁹⁷ In these cases, the trial court often issues to the jury a “‘conscious avoidance’ charge, also known as a ‘willful blindness’ instruction”¹⁹⁸ or an “ostrich instruction, because the defendant is considered by the court to have, figuratively, stuck his head in the sand to avoid learning truths that would otherwise have been patently obvious to the average reasonable person.”¹⁹⁹

For the more common cases of illegal drug distribution, the instructions have been used where the defendant is accused of transporting drugs in a suitcase or handbag and claims not to have been aware that the bag contained the drugs. The instructions, however, have been borrowed from that setting and applied in cases against physicians who prescribed drugs to patients who subsequently diverted them. In these cases, the prosecution argues that the physician “deliberately ignored facts that would have led [a reasonable physician] to believe the patient was diverting the drugs.”²⁰⁰

A willful blindness instruction is inappropriate in this context as it undermines the doctor-patient relationship. I have argued elsewhere that:

[d]octors . . . must develop a trusting relationship with their patients, which requires them to listen to their patients and believe their accounts of their symptoms . . . [T]his is especially true in the field of pain management where there is no objective test for pain. Neither is there a wholly accurate test to determine whether the patient is telling the truth or fabricating his symptoms. Physicians who ignore their patient’s pain accounts would be arguably negligent. Prosecutors and the DEA argue that “doctors violate the law when they prescribe pain pills to patients who they know—or reasonably should know—are selling or abusing the drugs.” But, this puts physicians in the position of being watch dogs for law enforcement or, at least, suspicious of their patients’ claims of pain.²⁰¹

Deborah Hellman, in an article that focuses on the use of the willful blindness instruction in these cases and whether the physician’s professional

197. Hoffmann, *supra* note 4, at 276 (quoting Deborah Sprenger, Annotation, *Propriety of Instruction of Jury on “Conscious Avoidance” of Knowledge of Nature of Substance or Transaction in Prosecution for Possession or Distribution of Drugs*, 109 A.L.R. FED. 710, 713, § 2[a] (1992)).

198. *Id.*

199. *Id.* at 276 n.340 (quoting Sprenger, *supra* note 197, at 710, 713, § 2[a]) (internal quotation marks omitted).

200. *Id.* at 276–77.

201. *Id.* at 303 (footnotes omitted). Dr. William Hurwitz, a pain doctor who was criminally prosecuted under this standard, has written that the standard “forces doctors who try to treat pain to act like police, reinforcing a perverse medical paternalism that subverts the ethical imperatives designed to protect patient autonomy and dignity. This distortion of the patient-physician relationship stigmatizes patients and erodes their trust.” *Id.* at 304 (quoting William E. Hurwitz, *Pain Control in the Police State of Medicine (Part II)*, 8 J. AM. PHYS. & SURGEONS 13, 14 (2003)) (internal quotation marks omitted).

obligations should provide a defense to the charges at issue, argues both that “[p]rosecuting doctors for being willfully blind to a patient’s wrongful reselling of drugs criminalizes physicians’ trust in their patients” and that “doctors treating patients in pain act rightly in trusting their patients, and thus the law erroneously imposes criminal sanctions on actions that are morally justified.”²⁰²

The expansion of the white-collar criminal law and drug control laws to include unintentional violations may also have led to recent criminal prosecutions of physicians for medical negligence. There are no comprehensive data on the number of cases in which physicians have been prosecuted for criminal negligence, but, while the numbers are quite small,²⁰³ they appear to be growing.

In 1990, the AMA commented that the “prosecution of physicians for clinical mistakes was ‘almost unknown.’”²⁰⁴ However, a series of criminal prosecutions of physicians in the late 1980s and early 1990s prompted the AMA to adopt a resolution “to insure that medical decision-making exercised in good faith, does not become a violation of criminal law.”²⁰⁵ In 1995, the AMA adopted a more formal statement on the subject condemning the “current trend” of the criminalization of medical malpractice.²⁰⁶ At the time of that statement, “the AMA estimated [that] only about [ten] physicians nationwide had been prosecuted for medical negligence” but feared increased prosecutions in this area.²⁰⁷ Two articles published in 2001 and one article published in 2007 describe cases where physicians were prosecuted for medical negligence in the recent past. Filkins identified nine cases between 1981 and 1995;²⁰⁸ Liederbach et al. identified fifteen cases between 1986 and 1999,²⁰⁹ and Kollas et al. reviewed five criminal prosecutions against physicians occurring between 1992 and 2005 involving palliative or end of life care.²¹⁰

202. Deborah Hellman, *Prosecuting Doctors for Trusting Patients*, 16 GEO. MASON L. REV. 701, 702 (2009).

203. See James A. Filkins, “*With No Evil Intent*”: *The Criminal Prosecution of Physicians for Medical Negligence*, 22 J. LEGAL MED. 467, 471–72 (2001) (noting that there are only fifteen reported appellate decisions of such prosecutions between 1809 and 1981).

204. *Id.* at 469–70 (quoting *Pennsylvania Prosecutor Finds No Grounds for Charges Against Surgeon*, AM. MED. NEWS, June 1, 1990, at 5).

205. *Id.* at 470 (quoting Morton M. Kurtz, *Criminalization of Medical Judgment, Resolution 223*, PROC. AM. MED. ASS’N INTERIM MEETING (1993)).

206. *Id.* (quoting *Criminalization of Health Care Decision-Making, Resolution 202*, PROC. AM. MED. ASS’N, INTERIM MEETING (1995)) (internal quotation marks omitted); see also Liederbach et al., *supra* note 3, at 164 (citing AMA Policy H-160.946).

207. Filkins, *supra* note 203, at 470.

208. *Id.* at 471–90. The cases actually include prosecutions of eight physicians and one corporation for medical negligence. *Id.* at 471.

209. Liederbach et al., *supra* note 3, at 150–56.

210. Kollas et al., *supra* note 8, at 234–36.

Research on these cases indicates that a common element is disagreement about the relevant standard of care. Filkins observed that these cases are often inappropriately addressed in the criminal justice system as prosecutors fail to establish that the physician breached a standard of care or that the physician's actions caused the patient's harm.²¹¹ Rather, the physician's state of mind acts as a substitute for careful scrutiny of the physician's actions and their impact on the patient's injury.²¹² He argues that "[a] defendant physician's state of mind should be weighed only after the issues of causation and standard of care have been resolved and all the facts considered. To do otherwise exposes physicians 'to potential criminal liability for their actions related purely to their exercise of professional clinical judgment.'"²¹³ Kollas et al. similarly concluded that establishing a violation of the standard of care was a weak link in the prosecution of a number of physicians who were charged with homicide for the death of patients who were terminally ill.²¹⁴

The justification for use of the criminal laws has traditionally included deterrence, rehabilitation, and retribution. When physicians are prosecuted for negligent acts, it is unlikely that such actions will have a deterrent effect. Deterrence is grounded in rational choice theory, which assumes actors weigh the costs and benefits of their acts. When their acts are not intentional, such a model has less explanatory value.²¹⁵ Alternatively, efforts to prosecute physicians for negligent acts may have an "anti-deterrent" effect. Liederbach et al. speculate that "when prosecutions occur, they will trigger an 'oppositional culture' among doctors, in which physicians band together to define such intervention as illegitimate and characterize the doctors to which they are applied as scapegoats of politically ambitious prosecutors."²¹⁶ If this is so, they conclude that "such resistance to control might create 'defiance' and produce effects that undermine deterrence."²¹⁷

The goal of rehabilitation is also unlikely to be met through criminal sanctions for negligent behavior. Arguably, these physicians could benefit from mentoring or retraining, but they will not be subject to these forms of

211. Filkins, *supra* note 203, at 498.

212. *Id.* at 498.

213. *Id.* at 498–99 (quoting *State v. Naramore*, 965 P.2d 211, 224 (Kan. Ct. App. 1998) (Brazil, C.J., dissenting)).

214. Kollas et al., *supra* note 8, at 237–38.

215. See Liederbach, *supra* note 3, at 166 ("[T]he extent to which white-collar offenders are deterrable by legal sanctions remains uncertain. This issue is likely to be complicated still further in the case of doctors, where the behavior targeted for deterrence is perhaps not intended nor due to rational calculation" (citation omitted)).

216. *Id.*

217. *Id.* But Liederbach et al. also hypothesize that such prosecutions could have a deterrent effect by creating stronger incentives for doctors to police their peers and adopt practices that reduce medical errors and improve patient safety. *Id.* at 167.

rehabilitation through the criminal justice system.²¹⁸ These educational approaches, however, could be imposed by state medical boards, if they were to become more active in disciplining these types of cases.

This leaves retribution as the primary objective for prosecution of physicians for gross medical malpractice. This justification for criminalization is least applicable when intent is absent.

D. Need for Law Enforcement Self-Assessment Regarding Impact

It also becomes clear, from reviewing physician lawbreaking and the law enforcement response, that there is a failure on the part of law enforcement to adequately evaluate its own effectiveness. For example, regarding the fraud laws and their enforcement, while there appear to be some indications that the increased expenditure on fraud control has had a deterrent effect, the impact of that effect is unknown.²¹⁹ Moreover, there appear to be few efforts to determine whether the costs associated with the system are commensurate with the benefit. Efforts to evaluate the cost-effectiveness of the laws and their enforcement seem to focus most often on return on investment, i.e., the number of government dollars spent on enforcement and the dollars recovered from fines and sanctions, rather than an effort to look at the full costs and benefits of the program to society.²²⁰ The latter, for example, would include the cost to physicians of compliance with the complex billing rules,²²¹ the costs of false positives (i.e., those physicians who are inappropriately captured, prosecuted, and sanctioned), the costs to patients who are unable to find a physician to treat them or who are denied care, as well as any benefits that may result from reductions in unnecessary treatment.²²² In addition, there does not appear to be

218. See generally Russell E. Farbiarz, *Victim-Offender Mediation: A New Way of Disciplining America's Doctors*, 12 MICH. ST. U. J. MED. & L. 359, 362 (2008) (noting that rehabilitation was "abandoned as the primary goal [of the criminal justice system] in the 1970's and 1980's" but that it could be reintroduced to physicians through victim-offender mediation).

219. See BERENSON ET AL., *supra* note 190, at 60.

220. See, e.g., *id.* at 61.

221. Sage has observed that "fraud compliance has become a full-time job for providers as well as enforcers, raising the risk of symbiotic bureaucracies that waste rather than preserve resources." Sage, *supra* note 189, at 1180.

222. An academic study by Becker et al., for example, analyzed the impact of increased support for fraud enforcement activities on the costs and quality of care provided to Medicare patients The authors concluded that increased fraud enforcement resources result in greater declines in expenditures . . . without evidence of an increase in adverse health outcomes. There were, however, significant differences in the effects of increased enforcement across different types of patients (e.g., age, gender, and race) and hospitals (e.g., ownership type, size, and location). BERENSON ET AL., *supra* note 190, at 60 (citing David Becker et al., *Detecting Medicare Abuse*, 24 J. HEALTH ECON. 189, 189–210 (2005)).

consideration of the potential benefit of alternatives to aggressive enforcement of the fraud laws.

There is some acknowledgement in the literature that the fraud laws were initially quite effective at reducing large scale fraud and blatant violations of the law such as “Medicaid mills” where physicians billed for services not rendered.²²³ Today, the law enforcement efforts related to these laws seem more targeted at uncovering fraud in mainstream medical practice where the wrongdoing is often based on technical violations of the law and is very costly to discover and prosecute.²²⁴ While enforcement efforts are assisted by whistleblowers, they still require painstaking record review and attention to minute billing details.²²⁵ These more recent efforts may have diminishing returns, especially when the violations are associated with technical oversights. Moreover, a recent report by AARP, based on interviews with several former government officials, found that “efforts to enlist beneficiaries[] [as whistleblowers to] help in identifying fraud have not been successful” due to the complexity of the Medicare billing rules and the “difficulty of distinguishing innocent billing errors from intentional fraud.”²²⁶

Finally, policy makers should consider the effectiveness of the fraud control laws and their enforcement in comparison to alternative approaches to combating fraud. Hyman argues, for example, “that Medicare has underinvested in prepayment claims review and has compensated for this by imposing very severe sanctions on fraudulent claims through the [False Claims Act] and other legal tools.”²²⁷ Similarly, in the area of prosecution of physicians for prescribing of opioids, the U.S. Drug Enforcement Administration (DEA) does not appear to have evaluated whether its efforts have reduced drug diversion and abuse and/or how those efforts have affected patient access to care.

Failure to assess their practices appears to be quite common among law enforcement entities. In his testimony before the Senate Subcommittee on Crime and Drugs in 2002, Rosenzweig pointed out that

there is virtually no data on whether or not criminal enforcement programs actually have a deterrent effect, much less assessments of the quantum of that effect. Instead, agencies prosecuting white-collar crime routinely report only

223. See Paul E. Kalb, *Health Care Fraud and Abuse*, 282 JAMA 1163, 1163 (1999).

224. See *id.*

225. See LIBBY, *supra* note 53, at 24 (“The government has broadened its definition of health fraud at a time that most ‘big time’ fraud in health care has been eliminated. Prosecutors are now increasingly forced to concentrate upon nit-picking technical interpretations of regulations to convict solo practitioners.”).

226. BERENSON ET AL., *supra* note 190, at 60.

227. *Id.* at 60–61 (citing David A. Hyman, *HIPAA and Health Care Fraud: An Empirical Perspective*, 22 CATO J. 151 (2002)).

the number of cases they have brought, without any attempt to determine the effectiveness of their activity.²²⁸

Nor do they appear to assess the costs of their activities beyond government expenditures.

These comments highlight a major difference between medical practice and law enforcement practice. While quality improvement has become an integral part of health care systems, the concept seems to be foreign to law enforcement. Law enforcement agencies do not appear to make efforts to assess the impact of their practices or whether they are achieving their ultimate goals and at what cost.

E. Need for System of Expert Advice to Law Enforcement

Many of the cases where law enforcement has “overreached” might have been avoided by prosecutors and law enforcement agents if they had consulted or collaborated with medical experts to determine whether the physician who was the target of their investigation was a threat to the public by virtue of their medical practice. This is especially true in the context of physicians arrested for the prescribing of opioids or for gross negligence. Such medical expertise could come from state medical boards. Arguably, there needs to be better collaboration between state medical boards and prosecutors. In a study of cases where physicians were prosecuted for drug diversion, Reidenberg and Willis found that in the large majority, state medical boards had not been consulted at all prior to the physician’s criminal indictment.²²⁹

In a number of other countries, e.g., Japan, New Zealand, Saudi Arabia, and India, physicians are prosecuted for medical acts largely because of the “lack of alternative forms of redress,” such as disciplinary actions by medical boards.²³⁰ Given the existence of these entities in the United States, however, it seems inappropriate to jump to the criminal justice system to address cases related to standards of patient care. State medical boards are certainly better equipped to evaluate acceptable medical practice and the threat of a physician’s practices to public welfare than are federal and state prosecutors.²³¹ Admittedly, state medical boards are often underfunded and understaffed and

228. Rosenzweig Testimony, *supra* note 62, at 155.

229. M.M. Reidenberg & O. Willis, *Prosecution of Physicians for Prescribing Opioids to Patients*, 81 CLINICAL PHARMACOLOGY & THERAPEUTICS 903, 905 (2007).

230. Edward Monico et al., *The Criminal Prosecution of Medical Negligence*, 5 INTERNET J.L., HEALTHCARE & ETHICS 1 (2007), <http://www.ispub.com/ostia/index.php?xmlFilePath=journals/ijlhc/vol5n1/criminal.xml>.

231. See Hoffmann, *supra* note 4, at 307 (arguing in the context of prosecution for drug diversion that medical boards are “better equipped to determine whether the volume and dosages of opioids prescribed for a patient are consistent with acceptable medical practice than are federal and state prosecutors”).

cannot devote the resources necessary to adequately police all cases of physician wrongdoing. But, there is no reason why federal law enforcement agents should not consult with state medical boards regarding the need for disciplinary action in a given case, especially before criminal prosecution. In addition, greater resources could be devoted to state medical boards, perhaps by reallocating resources currently being devoted to federal and state criminal enforcement of medical wrongdoing. Such a shift may both reduce the need for criminal action and improve the quality of medical care.

F. Physician Disobedience as Call for Further Scrutiny and Possible Legal Change

A final observation when looking across the ways in which law enforcement responds to physician violation of the law, is that when physicians intentionally violate the law to care for patients or engage in actions that might be categorized as civil disobedience, more often than not, they appear to be dealt with fairly by the individualized safety valves incorporated in the criminal justice system. Perhaps, as a result, initiatives to change these laws are often ineffective. Failure on the part of legislators to respond to bad law claims where physicians are being criminally prosecuted, however, may be based on an effort to signal moral wrongdoing rather than on evidence that the laws are providing greater benefit than harm. In many of these cases, legislators considered the *potential* negative patient impact of the laws and struck a balance between the competing policy and moral arguments that shape where the line is drawn between legal and illegal activity. While in some cases, the policy arguments might weigh in favor of repealing the law, legislators have decided that there are important values or moral reasons to keep the law in effect.

In many cases, however, the moral values that have tipped the balance in the legislative equation are not uniformly shared by society. Oftentimes these moral values may blind legislators to new policy arguments or empirical evidence. But, legislators should be open to new information and data about the impact and effectiveness of the laws that they passed, willing to consider a recalibration of the balance.

When physician lawbreaking in the patient's interest is fairly isolated, the criminal justice system may respond appropriately and compassionately. But when physician lawbreaking based on asserted fiduciary duties to patients becomes more widespread, policy makers should seek to collect and compile data on the impact of the law on patients. Initial assumptions underlying the passage of the law may have been misguided or not empirically supported. For example, discussions regarding the criminalization of physician-assisted dying came to the fore during the time that Dr. Jack Kevorkian was assisting

individuals end their lives.²³² The policy arguments put forth by those who opposed the legalization of physician-assisted suicide included concerns that vulnerable individuals, including the elderly, women, the uninsured, the poor, and people with limited education, would be overrepresented in the group of individuals who would take advantage of the service, as they would be “considered marginal and expendable and come under pressure to end their lives prematurely.”²³³ Ten years of experience and empirical data from Oregon, where physician-assisted suicide is legal, have shown that these concerns have not been borne out.²³⁴ Instead, the results indicate an improvement of end of life care in Oregon and, in particular, knowledge of palliative care and use of hospice.²³⁵

Initiatives based on empirical data of the impact of various laws on patient care may help to persuade policy makers of the need to change existing laws. On the other hand, policy arguments cannot necessarily counter moral concerns. Yet, by providing better data to inform policy arguments and challenge unfounded views, the debate can be narrowed down to the core issues at stake, whether they are morally, policy, or politically driven.

In conclusion, I agree with Professor Johnson that when we encounter a situation where physicians complain about bad law because it prevents them from appropriately treating patients, we should take such claims seriously and legislators should treat them as sentinel events. This is especially true when physicians break the law, not out of some selfish motive, but in order to provide better care to their patients. And, even when doctors who break the law have motives that are difficult to disentangle but may include dual motivations, i.e., patient care and economic gain, we should not ignore them but rather urge greater efforts at evaluating the impact of these laws on patient care.

232. See *supra* text accompanying notes 149–62.

233. KATHRYN L. TUCKER, AM. CONSTITUTION SOC’Y FOR LAW & POLICY, CHOICE AT THE END OF LIFE: LESSONS FROM OREGON 8 (June 2008), <http://www.acslaw.org/files/Kathryn%20L.%20Tucker%20Issue%20Brief.pdf> (citing Brief for Not Dead Yet et al., as Amici Curiae in Support of Defendants-Appellants, *Glucksberg v. Washington*, 521 U.S. 702 (1997)).

234. See Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in “Vulnerable” Groups*, 33 J. MED. ETHICS 591, 597 (2007) (“[W]e found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.”).

235. See TUCKER, *supra* note 233, at 9. Based on this data, recently the American Public Health Association and the American College of Legal Medicine joined the American Medical Women’s Association and the American Medical Students’ Association in adopting policies supporting the practice of aid in dying. *Id.* at 12.