# THE DISPARITY IN STATE-BASED QUALITY OF CARE DISCIPLINARY STANDARDS

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## ABSTRACT

**This article explores the fact that current state-based physician disciplinary statutes display a great lack of uniformity between states regarding the threshold standards used to determine when a physician can be disciplined for substandard patient care. Many states use a gross negligence standard to make the determination; others use a lower, ordinary negligence standard; and other states use both standards in the same statute. Among gross negligence states, there are many different statutory and case law definitions of "gross negligence" in use, adding to the lack of harmony. The lack of uniformity in state-based regulatory laws and standards is an issue in the national debate over the efficacy of state-based physician regulation. The true dimension of this multiplicity of disciplinary standards and definitions cannot accurately be assessed without a detailed study of how state medical boards actually interpret and apply these terms, and whether there is a resulting observable impact on how many physicians are disciplined from state to state for quality of care mistakes. However, even the appearance and perception that some states treat patient care more strictly than others may create regulatory issues that might require resolution through an effort to bring disciplinary negligence standards between the states into conformity with one another.**

## INTRODUCTION

State-based disciplinary systems are still the primary method for regulating physician conduct and competency in the United States today. Although regulatory control remains local, state medical boards are constantly faced with the challenge of evaluating whether their locally shaped disciplinary statutes and regulations should be revised to become more consistent with the regulatory structures of other states. One area of physician regulation that has not been placed squarely under the uniformity microscope is the discipline of physicians who have provided substandard care to their patients. A study of 51 jurisdictions in the United States, conducted specifically for this article, reveals that there are no consistent statutory structures from state to state for defining when a state medical licensing board may take disciplinary action against a physician for medical negligence.[1] This article will explore the nature and scope of this disharmony and examine some of the implications of a state-based regulatory system in which the disciplinary framework in quality of care cases is different in virtually every jurisdiction.

The need for uniformity and consistency across state lines in physician licensing laws has been the subject of several initiatives in recent years. In a 1998 policy document, *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession,* the Federation of State Medical Boards (FSMB) issued a clearly articulated call to the state medical boards to engage in an ongoing process of statutory revisions that would help the states attain uniform standards and procedures between the states.[2] This *Blueprint* policy adopted the recommendations of the Special Committee on Uniform Standards and Procedures, a committee commissioned with a "profound sense of urgency," in response to the concern that the viability of a state-based system of physician licensure and discipline might depend in part on improving medical board consistency and promoting uniform standards for the effective regulation of the medical profession. This call to arms has been supported by other FSMB initiatives, such as the policy document *A Guide to the Essentials of a Modern Medical Practice Act, 10th Edition*,[3] policy statements on the evaluation of quality of care and maintenance of competence[4] and the role of ethics in quality of care decisions,[5] as well as current efforts to perfect license portability.

The *Blueprint* includes recommendations for upgrading medical board disciplinary regulations, focusing attention on

the need for uniformly recognized standards in due process procedures, investigatory procedures, reciprocal disciplinary actions, board order formats and conflict of interest policies. The prefatory remarks to the *Blueprint* acknowledge that comprehensive, effective regulation of the medical profession would include, among other features, recognition between various jurisdictions of standard definitions for their most-used terms and commonly accepted definitions of substandard or inappropriate physician behavior.

Most medical boards in the United States have striven to meet the call. Current statutes and administrative codes all reflect that serious efforts have been made to update physician licensing and disciplinary provisions, especially in the areas of physician incompetence and remediation, physician misconduct for sexual boundary violations, deceptive practices, advertising and other ethical issues. Statutory due process structures have become more uniform as well. This movement towards uniformity between the states is not reflected from state to state, however, in the disciplinary laws that delineate the threshold for imposition of discipline upon physicians for substandard patient care.

## QUALITY OF CARE DISCIPLINARY THRESHOLDS: "ORDINARY" NEGLIGENCE VERSUS "GROSS" NEGLIGENCE

Quality of care discipline may appear in several different formats in any given physician licensing and disciplinary statute. Most states have an investigatory process that requires the screening of civil medical malpractice suits and settlements in addition to quality of care complaints made directly to the licensing board. Many state statutes have "multiple occurrence" scrutiny in place, where investigatory review for repeated negligence is automatically triggered for physicians who are reported to have had multiple complaints or suits within a small period of time, such as three events during a five-year period. A few states have additionally made civil medical malpractice findings into independent grounds for discipline.[6] Many states even have some standards of care built right into the disciplinary statute, usually in practice areas of heightened concern such as drug prescription practices.

While the above-described types of statutory provisions may help generate some of the quality of care issues that may become the subject of physician discipline, the true threshold in almost every state regulatory scheme is the provision that defines what standard of medical negligence will subject a physician to discipline.[7] There are fissures between different state definitions of negligence, however, that separate the states into three basic categories of quality of care regulation: 1) those states in which a physician may be disciplined only for "gross negligence"; 2) those states where physicians may be disciplined for "ordinary negligence"; and 3) those states which maintain statutes containing both gross negligence and ordinary negligence concurrently as standards for the imposition of discipline. These interstate inconsistencies are exacerbated by the fact that among the states using a gross negligence standard, there is no uniform definition of "gross negligence" in use and, in fact, there are quite a few state medical boards that do not have any statutory definitions whatsoever for "gross negligence."[8] Even the courts have not achieved uniform results in the few reported cases in which the definition of gross negligence has been directly addressed.[9] When all of these factors are taken into consideration, it is fair to say there may not be two states expressly regulating quality of care discipline for physicians in the same way.

## THE "ORDINARY NEGLIGENCE" STATES

At least 13 states[10] use an ordinary negligence standard as the sole threshold test for defining culpable conduct warranting discipline for quality of care mistakes. This is the threshold recommended by the FSMB, which, in the *Essentials* model medical practice act, recommends two methods by which a physician licensing board should be authorized to take disciplinary action for substandard care: 1) for "negligence in the practice of medicine as determined by the Board"; and 2) for "any adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section …."[11] This category of quality of care disciplinary culpability will be referred to here as "ordinary negligence," although in disciplinary statutes the term usually appears as "negligence" or "malpractice." The ordinary negligence standard is distinguished from the gross negligence standard by the fact that an ordinary negligence finding does not require proof of the severity of the negligence, but only a determination that the medical practice in question failed to meet the established standard of care.[12]

## THE "DUAL STANDARD" STATES

Another 13 states[13] have disciplinary statutes containing both an "ordinary" negligence and a "gross" negligence standard. The significance of the dual standard in these states is not especially clear because many of these states do not have statutory provisions explaining when the ordi-

nary negligence standard is to be used, and when gross negligence would control.[14] Theoretically, an ordinary negligence standard would be broad enough to cover any case where gross negligence had occurred, and would be less complicated to prove than gross negligence, so the need for maintaining both standards simultaneously is not immediately obvious. Vermont has recently added an ordinary negligence standard without eliminating the pre-existing gross negligence standard, so it may be some of the other dual standards have evolved in this way.[15] The medical boards in some of these dual standard states undoubtedly have internal understandings for determining when to use ordinary negligence and when to use gross negligence, but the role each standard plays in determining which physicians will be disciplined and which will not is not transparent through statute or code.

## DEFINITIONAL INCONSISTENCIES IN STATES USING "ORDINARY NEGLIGENCE

Although gross negligence standards show the greatest divergence, as will be discussed below, even the ordinary negligence states show variations between the definitions currently in use. Some ordinary negligence states require express proof that injury was caused by the negligence.[16] Another variation occurs around the scope of the standard of care to be used, some states explicitly requiring that the standard of care used be limited to that which is acceptable in the locality in which the physician practices, while other states are silent on this issue.[17]

## THE "GROSS NEGLIGENCE" STATES

Seventeen[18] states use a gross negligence standard as the sole threshold provision for defining when discipline and sanctions will be imposed for quality of care violations. Another 14 states,[19] as described in the preceding section, are dual standard states that use a gross negligence standard in conjunction with an ordinary negligence standard. The definitions of "gross negligence" appear for some states in the statutes and administrative codes applicable to the medical board, and in other states, most notably New York and California, the definition has been developed through case law.[20] Although nearly all of these 31 jurisdictions has a differently worded definition for the meaning of "gross negligence," there are some general definitional groupings that are helpful for examining whether the lack of uniformity is significant. The groupings, which will be informally described in this article as the "degree of deviation definitions," the "mental state" definitions, and the "pejorative" definitions, are distinguished by the type of proof that is required in each definition for a medical board to make the finding that the physician's conduct was indeed "gross."

### 1) The "degree of deviation" definitions

This definition de-emphasizes, if not eliminates, the necessity of proving the physician's awareness of his or her conduct as the physician acted or failed to act, otherwise known as the physician's "mental state." This definition instead requires an assessment of the degree to which the flawed medical practice fell below the standard of care. The California definition of "gross negligence" for medical discipline purposes, developed in the case of *Gore v. Board of Medical Quality Assurance*, is a good example: "the want of even scant care or an extreme departure from the ordinary standard of conduct," which is further explained as "the want of even slight care, but not necessarily involving wanton or willful misconduct; in other words, an extreme departure from the ordinary standard of care," "very great negligence" and "more than ordinary inadvertence or inattention, but less than conscious indifference to consequences …."[21] This definition, read for plain meaning, seems to place the medical board's focus on the medical procedures themselves and to require an objective analysis of how greatly the care actually provided differed from what should have happened for the patient.

### 2) The "mental state" definitions

The many gross negligence definitions falling into this category all seem to require a finding of "gross" must be founded on proof sufficient to allow an inference to be drawn about the mental state of the offending physician, in addition to the analysis of whether the standard of care was breached. Under this standard, the negligence in question would rise to the level of "gross" if the nature of the deficiencies in care that occurred would allow the medical board to conclude that the physician was acting recklessly, or with conscious indifference or entire disregard to the welfare of the patient. This was explained well in one of the earliest cases to articulate a standard for medical gross negligence, as "that entire want of care which would raise a presumption of conscious indifference to consequences; an entire want of care, or such a slight degree of care as to raise the presumption of entire disregard for, the indifference to, the safety and welfare of others; the want of even slight care of diligence."[22] Arkansas case law describes gross negligence as "the failure to observe even slight care; it is carelessness or recklessness to a degree that shows utter indifference to the consequences that may result. . . ."[23]

Illinois medical board administrative code and case law define gross negligence as "an act or omission which is evidence of recklessness or carelessness toward, or disregard for, the safety or well-being of the patient and which results in injury to the patient."[24] Missouri case law requires "an act or course of conduct which demonstrates a conscious indifference to a professional duty."[25] Some states even go as far as requiring "willful" conduct, which implies an actual awareness that harm may result, such as in Oregon case law: "gross negligence," as the term is generally used, connotes an act beyond mere inadvertence or error in judgment; it must be error 'of such magnitude or recurrence' that a willful indifference to the consequences of the act may be inferred."[26]

### 3) The "pejorative" definitions

Another set of "gross negligence" definitions are clustered around the use of somewhat pejorative adjectives intended to be attributed to the nature of the physician's conduct as a way of describing "gross." Pennsylvania case law has recognized that gross negligence would exist where "the facts support substantially more than ordinary carelessness, inadvertence, laxity or indifference. The behavior of the defendant must be flagrant, grossly deviating from the ordinary standard of care …. Gross negligence is merely the same thing as ordinary negligence, with the addition of … a vituperative epithet."[27] Nebraska, for instance, recognizes that gross negligence is achieved when the conduct is found to be "flagrant, shameful, not to be excused."[28] Under Massachusetts case law, the conduct described must be "flagrant and extreme,"[29] and New York and New Jersey both require a finding that the deviation from the standard of care be "egregious."[30]

## DISTINCTIONS WITHOUT A DIFFERENCE?

The gross negligence standard clearly has been allowed to inconsistently infiltrate disciplinary statutes and case law. Without a detailed comparative study of board decisions containing findings and rulings applying these various gross negligence definitions, it is hard to say whether all these apparent dissimilarities actually matter. Any medical board facing these definitions as written would be justified in finding that different types of proof might be required. Further, medical boards will not find any guidance for determining whether evidence that appears to be sufficient to support a finding of "extreme deviation from the standard of care" would also be sufficient to support a finding of "flagrant and shameful" conduct or "conscious disregard for patient safety." Although there is some case law outlining the various gross negligence definitions, the cases are not finely tuned enough to compare the different definitions as they are applied to actual factual situations. A review of available case law would show that, while there are certainly recognizable factual scenarios upon which gross negligence findings have been upheld, the results so far seem to be the same regardless of which particular gross negligence definition was applied during the analysis.[31]

The best evidence to help in deciding whether this plurality of gross negligence standards and definitions is fostering inconsistent and unfair results for licensees and the public is buried within the relatively inaccessible written adjudicatory decisions of medical boards across the United States. It is in these decisions that the board decision-makers must align findings of fact and applicable law and determine whether culpability has been proven. An organized dissemination and examination of these decisions must be done before any final conclusions are drawn about the apparently inconsistent standards that can currently be found in disciplinary laws governing quality of care discipline.

## IMPLICATIONS OF THE LACK OF UNIFORMITY IN QUALITY OF CARE DISCIPLINARY STANDARDS

There is no question there exists a fundamental difference between the ordinary negligence standards used in many states, and the gross negligence standard used in a minority of states. Ordinary negligence is a lower threshold, and therefore creates an environment where physicians can be punished for substandard care that would not be subject to sanction in a gross negligence state. The multiplicity of gross negligence definitions in use raises the concern the gross negligence threshold may not be uniformly administered either among states already authorized to screen out ordinary negligence quality of care complaints. There are several issues to consider in deciding whether these disparities make the negligence disciplinary threshold a candidate for uniformity reforms. In essence, the appearance of unfairness and inconsistency may not be the reality, or the most important consideration when local control issues are at stake.

### The Arguments for Uniformity

Basic fairness to physician licensees is a major consideration in considering whether the states should be strongly encouraged to adopt the same quality of care threshold standard. Board discipline is one of the triggers for report-

ing physicians to the National Practitioners Data Bank. Also at stake are insurance consequences, license portability and reputation. It is not fair to maintain a system where some physicians may suffer serious consequences for conduct that would go undisciplined and maybe even undisclosed for another physician, based simply upon the state in which the physician practices.

The lack of uniformity is also a barrier to effective enforcement of the license reciprocity provisions that kick in when a medical board learns that a current licensee or license applicant has been disciplined in another state. These provisions usually require the medical board to determine whether the discipline in the other state was for conduct that would qualify for discipline in the new state. This analysis is complicated and burdensome when the new board is forced to determine whether what was judged discipline under another state's ordinary negligence standard would qualify for gross negligence in the state being petitioned. Such significant variations create divisions between states instead of promoting mutual respect and coordination, and impede the ability to give full faith and credit to another state's physician discipline.

Continuing to allow different standards for disciplining substandard patient care to flourish from state to state may also be unwise because such state-to-state variances without any visible justification may undermine public confidence in the ability of a state-based regulatory system to protect patients. The disparity creates a perception that patient safety and quality of care is arbitrary, and some states are safer for patients than others. There could be understandable public consternation engendered by the realization that, as a matter of official policy, a physician in a "gross negligence" state could continue to commit lower level non-similar malpractice on multiple occasions that would be stopped through disciplinary intervention in an "ordinary negligence" state.

Finally, lack of uniformity prevents different state boards from being truly helpful to each other. Presently, the medical boards across the nation do not speak the same language on the type of case that those boards spend most of their time evaluating. This weakness is especially acute given so many of the nation's medical board decision-makers are volunteer medical specialists and public members working in inadequately resourced environments. Medical boards need resource support to do their jobs well, and boards cannot build on each other's collective wisdom when they do not use the same standards and speak the same language. This dissonance also makes the job of evaluating board performance much more complicated.

### The Argument for Local Control and Maintenance of Diverse Standards

The very state-based health care regulatory system that permits such a large legal divide to exist between the states is also the most important guarantor that each state can design a regulatory system tailored to the needs of it citizens, the quality of its health care community and the resources available to support responsible regulatory action by medical licensing boards.[32] Quality of care complaints and collateral review of civil malpractice events constitute the largest percentage of any state medical board's investigatory caseload. A state legislature that lowers the disciplinary threshold to ordinary negligence and/or makes civil malpractice results into grounds for discipline in a previously "gross negligence-only" state must assume the disciplinary caseload may increase significantly. The conversion to "ordinary negligence" cannot be performed to improve public confidence without a concomitant commitment to increase funding and staffing to handle the increased investigation, prosecution and adjudicatory burdens that will follow. To do any less will be to set up the medical board for failure and loss of the very public confidence that the change of standard was intended to inspire.

Real study should also be conducted before concluding the gross negligence/ordinary negligence dichotomy must be eliminated in favor of a national, uniformly defined ordinary negligence standard for all quality of care complaints against physicians. State board decisions should be studied and reliable data collated to determine whether in fact the ordinary negligence standard already being used produces more physician disciplinary results than gross negligence has. All board members know that the fact that a case qualifies for discipline does not mean that discipline is automatically imposed. State medical boards are usually granted varying degrees of decision-making discretion and the power to make nonpublic, non-disciplinary settlements in appropriate cases. Efforts should be made to determine whether the use of this discretion affects at all the actual number of physicians disciplined and sanctioned for delivery of substandard care in ordinary negligence states. Ordinary negligence may not automatically mean more discipline and sanctions.

Finally, in favor of caution is concern for fairness and due

process. If state boards with statutory mandates to prosecute ordinary negligence cannot fulfill that mandate due to inadequate resources, those boards may be forced to use discretionary powers to settle or dismiss cases at a non-disciplinary level in order to control the more expensive disciplinary caseload. If the state boards engage in this method of caseload control without any articulated or publicized standards for doing so, there is a risk of creating the perception, if not the reality, of arbitrary use of power and consequential loss of confidence from the public and the licensee community as well. It could be better from a board performance perspective to have a more selective, but visible and administratively affordable threshold such as gross negligence that can be consistently enforced and that promises known disciplinary results when invoked.

## CONCLUSION

Significant disparities exist among state medical boards as to the standards currently being used for imposing discipline upon physicians against whom quality of care complaints have been filed. A full third of the states still use gross negligence as the sole threshold for deciding disciplinary culpability, and the remainder of the states use a more inclusive "ordinary negligence" standard, or some combination of ordinary and gross negligence, and several states use neither. Fragmentation further exists among states using a gross negligence standard, because multiple definitions of gross negligence requiring different elements of proof are in use among the gross negligence states. Concern exists for the impact of this lack of uniformity on the reliability of and public confidence in the current state-based regulatory system, but the need for a movement toward uniformity is not clear until further comparative study determines whether the observed disparities produce actual disparate and unfair results. Such study should be done in order to either quell any unease that comes from the knowledge that physicians can be disciplined differently from state to state for delivery of substandard patient care or to point the way toward the disciplinary standard that can best serve the regulatory goals of public safety and fairness to licensee physicians.

## REFERENCES


1. This study was conducted by the author during Dec. 2004-Jan. 2005, and consists of an independent review of state statutes, administrative codes and selected case law relating to physician regulatory discipline. Disciplinary laws relating to osteopathic doctors and physician assistants were not specifically examined, although in many states, these professions are regulated by the same statutes as, or statutes identical to, those for physicians.
2. The Federation of State Medical Boards of the United States, Inc. *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession*. 1998.
3. The Federation of State Medical Boards of the United States, Inc. *A Guide to the Essentials of a Modern Medical Practice Act, 10th Edition*. 2003.
4. The Federation of State Medical Boards of the United States, Inc. *The Special Committee on Evaluation of Quality of Care and Maintenance of Competence*. 1998.
5. The Federation of State Medical Boards of the United States, Inc. *Ethics and Quality of Care: Report of the American Medical Association and the Federation of State Medical Boards*. 1995.
6. Montana, Nevada, Rhode Island and Texas are some of the states in which discipline may be imposed for civil malpractice results.
7. The following are some of the states which have physician discipline statutes that do not have a quality of care discipline standard explicitly grounded on either "ordinary" or "gross" negligence standards: Maine, Maryland, Mississippi, South Carolina and South Dakota.
8. Some state statutes and administrative codes using a statutorily undefined "gross negligence" standard can be found in Alaska, Delaware, District of Columbia, Hawaii ("hazardous negligence"), Iowa, Massachusetts, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Tennessee and Utah. A few of these state boards have judicially fashioned definitions of "gross negligence" to guide their decision-making. It is permissible, and of course necessary, for a disciplinary board in a definition-challenged state to fashion a definition appropriate to that state. The board could look first to sources within the home state to determine whether gross negligence has been defined for some other legal purpose in the state statutes or case law. Examples of potential sources of definition guidance might be other statutes enacted by that state's legislature, such as emergency personnel or volunteer "Good Samaritan" statutes. There may be case law from the courts defining common law "gross negligence," or gross negligence under institutional or governmental tort immunity, or criminal law concerning intervening circumstances which excuse criminal liability, which

can sometimes include intervening medical gross negligence. If no adequate intrastate guidance can be found, the board could reach out to licensing case law in other jurisdictions and choose a definition that seems appropriate to the board's understanding of its particular licensing and disciplinary mandate, or seems consistent with the unrelated gross negligence precedent found within the home state.

9. For a sampling of the case law defining "gross negligence" in the physician discipline setting, see the following cases: *Gore v. Board of Med. Qual. Assur.*, 167 Cal.Rptr. 881 (Cal. 1980); *Rho v. Ambach*, NYS2d 1005 (1989); *Enu v. Sobol*, 617 NYS.2d 960 (1994); *In the Matter of Jascalevich*, 442 A.2d 635 (NJ 1982) ; *Langvardt v. Nebraska*, 581 NW2d 60 (Neb. 1998); *Hellman v. Board*, 537 NE2d 150 (Ma. 1989); *Poole v. Iowa Board of Medical Examiners*, 2000 WL 193612 (Iowa 2000)(unpublished opinion); *Paulsen v. Illinois Dept.*, 739 NE2d 536 (Ill. 2000); *Bloom v. Dubois Reg. Med. Ctr.*, 597 A.2d 671 (Pa. 1991); *Bever v. State Board*, 2001 WL 68307 (MoAppWD 2001); *Britton v. Board*, 632 P.2d 1273 (Ore. 1981); *Livingston v. Arkansas Board*, 701 SW2d 361 (Ark. 1986); *Woodard v. Brown*, 770 P.2d 1373 (Colo.App. 1989); *Yoshizawa v. Hewitt*, 52 F.2d 411 (Haw. 1931).
10. The "ordinary negligence" as sole threshold states are Colorado, Georgia, Louisiana, Idaho, Minnesota, Montana, Nevada, North Carolina, Ohio, Texas, Virginia ("intentional or negligent conduct"), Washington and Wisconsin.
11. *Essentials*, *supra* note 3.
12. The Alabama statute, 545-X-3-.01(1)(l), has helpful definitions of the two standards: "Malpractice as used in these rules shall mean negligence. Gross malpractice shall mean gross negligence. Negligence shall mean the failure to do that which a reasonably prudent physician would have done under the same or similar circumstances, or the doing of that which a reasonably prudent physician would not have done under the same or similar circumstances. Gross negligence is the conscious doing of an act or the omission of some duty to act with a conscious disregard of known conditions of danger or with careless and reckless indifference to the consequences of such act or omission ...."
13. The "dual standard" states are: Arizona, District of Columbia, Florida, Illinois, Kentucky, Massachusetts, Nebraska, Oregon, Pennsylvania, Rhode Island, Vermont, West Virginia and Wyoming.
14. The dual standard states of Alabama, Arizona and North Carolina are exceptions, because they do provide some statutory guidance for how the ordinary and gross standards are meant to work together. In Arizona, for example, the threshold for discipline is ordinary negligence, but cases with a gross negligence finding qualify for imposition of enhanced sanctions.
15. See Vermont statute 26 V.S.A. sec. 1354 (a)(22) & (31)(b).
16. Illinois, Virginia, and Washington are among the states that require either proof of injury or proof of likelihood or unreasonable risk of injury to the patient as part of the negligence standard.
17. Some of the states in which it is required under the disciplinary negligence standard that the physician's conduct be assessed according to a local standard of care are Arizona, Idaho, Nebraska, Oregon, Pennsylvania and West Virginia.
18. The states using a gross negligence standard as the sole threshold for imposition of discipline in quality of care cases are: Alabama, Alaska, Arkansas, California, Delaware, Hawaii ("hazardous negligence"), Iowa, Kansas, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Tennessee and Utah.
19. The dual standard states are listed in note 13, *supra*.
20. The leading cases from these states are *Gore v. Board of Med. Qual. Assur.*, 167 Cal.Rptr. 881 (Cal. 1980) and *Rho v. Ambach*, NYS2d 1005 (1989).
21. *Gore v. Board*, 167 Cal.Rptr. at 887-888. Another example with different language can be seen in the West Virginia board rules sec.11-1A-12.2.c: "a serious act, or series of acts ...."
22. *Yoshizawa v. Hewitt*, 52 F.2d at 412. It should be noted that Hawaii's current statute requires a finding of "hazardous negligence."
23. *Livingston v. Arkansas State Medical Board*, 701 SW.2d at 363.
24. *Paulsen v. Illinois Department*, 739 NE.2d at 541, citing Ill. Code 1285.240(c).
25. *Bever v. State Board*, 2001 WL 68307 (Mo AppWD 2001). See also, Arizona board policy statement (available on Arizona Medical Board website): "Gross Negligence: Is an extreme departure from the standard of care; or conduct the physician knows or should know involves a high degree of probability that substantial harm will result; or is the product of reckless indifference to the result of an act," and the Alabama statute, *supra* at note 12.
26. *Britton v. Board of Podiatry Examiners*, 632 P.2d at 1279-1280.
27. *Bloom v. Dubois Reg. Med. Center*, 597 A.2d at 677-

680 (citing, in part, Prosser and Keeton on Torts, 5th ed. 1984).

28. *Langvardt v. Nebraska*, 581 NW.2d at 70-71.
29. *Hellman v. Board*, 537 NE.2d at 152-153.
30. *Rho v. Ambach*, 74 NY2d at 1007; *Enu v. Sobol*, 576 NYS2d at 381 ("Gross negligence [in the New York physician statute] refers 'to an event of some duration occurring at a particular time or place, during which either a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount of egregious conduct could constitute gross negligence.'" See also, *In the Matter of Jascalevich*, 442 A.2d at 642-643 ("gross neglect" and "gross malpractice" suggest conduct beyond such wrongful action ... substantial and medically unjustifiable departure form the physician's duty to the patient ...").
31. Before generalizing based upon case law, it is important to note that the cases that are appealed and decided through the court system are not necessarily a representative sample of the full range of cases being adjudicated in the state medical board system. Judicially decided cases are also sometimes of limited utility for study because many appeal cases focus on other issues and the gross negligence determination receives perfunctory treatment. Nevertheless, case law is helpful. Gross negligence findings have most often been found in the following categories:

    **Failure to diagnose or conduct diagnostic tests or appropriate follow-up:** *Wahba v. NYS Dept.*, 716 NYS2d 443 (2002); *People v. Brown*, 770 P.2d 1373 (1989); *Gore v. Board*, 167 Cal.Rptr. 881 (Cal. 1980); *Lajevic v. Dept.* 645 A.2d 348 (Pa. 1994)(dentist); *Gandianco v. Sobol*, 567 NYS2d 909 (NY 1991); *Britton v. Board*, 632 P.2d 1273 (Ore. 1981); *Gabaldoni v. Board*, 785 A.2d 771 (Md. 2001); *Kobrin v. Gastfriend*, 2002 WL 32156924 (Ma. 2002); *Parrish v. Kentucky Board*, 145 SW.3d 401 (Ky. 2004); *Vance v. Fordham*, 671 P.2d 124 (Utah 1983); *Camas v. Delaware Board*, 1995 WL 717272 (Del.Super.1995); *State v. Sanderson*, 550 SW.2d 236 (Tenn.1977); *Langvardt v. Nebraska*, 581 NW2d 60 (Neb. 1998); *Bloom v. Dubois Reg. Med. Ctr.*, 597 A.2d 671 (Pa. 1991); *In the Matter of Jascalevich*, 442 A.2d 635 (NJ 1982); *Woodard v. Brown*, 770 P.2d 1373 (Colo. App. 1989).

    **Failure to take appropriate emergency action:** *Rosi v. Board*, 665 P.2d 28 (Alaska 1983); *Wahba v. NYS Dept.*, 716 NYS2d 443 (2002); *Schwalben v. Comm'r Health NY*, 696 NYS2d (NY 1999).

    **Wrong act or decision:** *Pearl v. NYS Board*, 744 NYS2d 64 (NY 2002); *Kaphan v. DeBuono*, 702 NYS2d 438 (NY 2002); *Weisenthal v. NYS Board*, 671 NYS2d 568 (1998); *Poulard v. Comm'r Health NY*, 608 NYS2d (NY 1994); *Franz v. Board*, 642 P.2d 792 (1982); *Livingston v. Arkansas Board*, 701 SW2d 361 (Ark. 1986); *Gupta v. DeBuono*, 654 NYS2d 426 (1997); *Braun v. Board*, 702 A.2d 124 (Vt. 1997)(dental); *Fitzgerald v. Board*, 506 NE2d 712 (1987)(vet); *Enu v. Sobol*, 617 NYS2d 960 (1994); *Oliver v. Kentucky Board*, 898 SW2d 531 (Ky. 1995); *Taylor v. Dept. Commerce*, 952 P.2d 1090 (1998)(vet); *Escobar v. Board of Medicine*, 560 So.2d 1355 (Fl. 1990); *Lopez v. N. Mexico Board*, 754 P.2d 522 (NM 1988); *Enu v. Sobol*, 617 NYS.2d 960 (1994); *Glover v. Board*, 231 Cal.App.3d 203 (C.A.Cal AD1 D.5 1991); *Britton v. Board*, 632 P.2d 1273 (C.A. Ore. 1981).
32. The importance of local control for state medical boards has been recognized by the FSMB in the *Blueprint* policy: "The Federation strongly believes that the state-based system retains a flexibility and sensitivity to local concerns that would inevitably be lost in a national system, and allows for the evolution and testing of a range of new approaches to improve the regulation of the medical profession in a number of jurisdictions at once." The *Blueprint* policy, *supra* at note 2, "Introduction and Charge."