COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

BEFORE THE STATE BOARD OF MEDICINE

COMMONWEALTH OF PENNSYLVANIA,
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

v.

KERMIT BARRON GOSNELL, M.D.,
LICENSE NO. MD-009422E
Respondent

DOCKET NO. 0155-49-11
FILE NO. 11-49-01059

FINAL ADJUDICATION AND ORDER

KATIE TRUE, COMMISSIONER
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

JAMES W. FREEMAN, M.D., CHAIRPERSON
STATE BOARD OF MEDICINE

2601 North Third Street
Post Office Box 2649
Harrisburg, Pennsylvania 17105-2649

TAL

HISTORY

This case came before the State Board of Medicine (Board) for review of the report and order of the hearing examiner issued on November 18, 2011. The history of this case is set forth in the report and order of the hearing examiner. Following issuance of the hearing examiner's report and order, the Board issued a notice of review on December 7, 2011. On or about January 3, 2012, Respondent, through his legal counsel, filed a brief for review of the adjudication and order. On or about January 10, 2012, the Commonwealth filed a brief in response to Respondent's brief for review of the adjudication.

The Board reviewed the entire record in this matter at its meeting on January 24, 2012, and now issues this adjudication and order in final disposition of the matter. The report and order of the hearing examiner is appended to this adjudication and order of the Board as "Attachment A."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

It is consistent with the authority of the Board under the Medical Practice Act of 1985 (Act), Act of December 20, 1985, P.L. 457, No. 112, *as amended*, 63 P.S. §422.1 *et seq.*, and the Administrative Agency Law, 2 Pa. C.S. §504, for the Board to adopt the findings of fact, conclusions of law, and discussion of the hearing examiner if the Board determines that they are complete and supported by the evidence.

The Board has reviewed the entire record in this case and reached the conclusion that the findings of fact, conclusions of law, and discussion of the hearing examiner are supported by the evidence and the law. The Board, therefore, adopts the findings of fact, conclusions of law and discussion of the hearing examiner. The Board hereby incorporates the hearing examiner's findings of fact, conclusions of law, and discussion by reference as if they were set forth fully in this adjudication and order.

The Board adds the following discussion to address Respondent's brief for review and the Commonwealth's brief in response to Respondent's brief for review.

Essentially, Respondent raises two issues in his brief for review. First, Respondent argues that the hearing examiner incorrectly found that Respondent was required to purchase "tail coverage" upon the termination of a "claims made" policy when no such requirement exists within the Medical Care Availability and Reduction of Error Act (Mcare Act). Second, Respondent asserts that his assets and property were seized, and his bank accounts were frozen, by the Office of the District Attorney of Philadelphia County (a governmental entity), causing Respondent to be unable to pay the premium for "tail coverage," and that this inability to pay must be considered when determining the sanction to be imposed upon Respondent. The Board rejects the Respondent's aforementioned arguments.

In support of his first argument, Respondent asserts that the regulations that the hearing examiner relied upon (at 31 Pa.Code §§ 242.2 and 242.17) to interpret the requirement of "tail coverage" are based on a repealed law (i.e., the Health Care Services Malpractice Act) which was replaced in 2002 by the Mcare Act. The Board rejects the Respondent's argument. Respondent's claim that the regulatory requirement to purchase tail coverage no longer applies is in direct contradiction to the language of §5107 of the Mcare Act, which provides, in pertinent part, as follows: "Orders and regulations which were issued or promulgated under the former act of October 15, 1975 (P.L. 390, No. 111), known as the Health Care Services Malpractice Act, and which are in effect on the effective date of this section shall remain applicable and in full force and effect until modified under this act." Thus, the existing regulation found at 31 Pa. Code §242.2 which states that: "in the case of a claims made policy permitted under sections 103 and 807 of the act (40 P.S. §§ 1301.103 and 1301.807), the insurance requirements of the act require purchase of the reporting endorsement (that is, tail coverage) or prior acts coverage or its substantial equivalent by the health care provider, upon cancellation or termination of the claims made policy" still retains its "full force and effect." Since the Mcare Act states that existing regulations remain applicable and in full force and effect until modified, and §242.2 of the regulations states that tail coverage is required, there can be no confusion about the continuing mandate for health care providers to procure tail coverage at the expiration of their claims made policies.

Respondent is misguided in his belief that he is not required to purchase tail coverage upon the termination of a claims made policy. As pointed out by the hearing examiner in her report and order and by the Commonwealth in its brief, Respondent violated the Mcare Act when he failed to purchase the requisite medical professional liability insurance coverage, also known

as "tail coverage," after his claims made policy expired. By failing to purchase tail coverage, Respondent no longer maintained professional liability insurance as required by the Mcare Act.

Respondent focuses on the fact that he maintained insurance while he was practicing medicine and suggests that that was enough. Respondent claims that he was no longer obligated to maintain professional liability coverage because, at the time of expiration of his claims made policy in March 2010, he was no longer "providing health care services." However, Respondent misses the critical point of tail coverage. Many instances of medical professional liability are raised well after the point of occurrence, and, thus, likely well after the expiration of a claims made policy. In fact, based on the statute of limitations, alone, in tort and contractual matters, claims of liability or breach are often brought years after their occurrence. As the hearing examiner points out in her adjudication and order (and the Commonwealth reiterates in its Brief in Response), Respondent "had a policy *during* the period in question but he did not have a policy *for* the period in question after that other policy ceased."

The hearing examiner, and the Board, agree with the logic set forth in the Commonwealth's Brief in Response:

> Respondent violated the Mcare Act at 40 P.S. §1303.711(c) when he failed to maintain current medical liability insurance after his claims made policy expired and/or was cancelled on March 17, 2010. Medical professional liability insurance is defined under the Mcare Act as "Insurance against liability on the part of a health care provider arising out of *any tort or breach of contract* causing injury or death resulting from the furnishing of medical services which were or should have been provided." 40 P.S. §1303.702 (emphasis added). Further, the definition of claims made coverage under the Mcare Act "...excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured." Essentially, claims made coverage excludes tail coverage by its very definition. It logically follows that, since tail coverage is specifically excluded, health care providers would need to purchase tail coverage in order to cover claims arising after the expiration or termination of claims made insurance, even if the underlying circumstances

giving rise to the claim occurred during a period in which the claims made coverage was in effect.

The Pennsylvania Supreme Court has spoken on this issue as well. In *Paternaster v. Lee*, 581 Pa. 28, 40, 863 A.2d 487, 495 (2004), the Supreme Court concluded that: "...given the essential character of CAT Fund coverage as excess coverage over and above available primary coverage and the Act's explicit requirement that providers maintain a certain level of primary coverage, we conclude that the CAT Fund director's regulations, which require health care providers to obtain a tail or similar policy to maintain CAT Fund coverage, *i.e.* 31 Pa. Code §242.2, 242.7(a)(2), and 242.17(d)(2), are completely consistent with the Act and were properly enacted by the CAT Fund director." This case further supports the conclusion that Respondent was required to purchase tail coverage.

The Board finds that the preponderance of the evidence supports the hearing examiner's reasoning and conclusion that Respondent was required to purchase tail coverage for the period of April 18, 2005, through March 17, 2010, and that by not doing so, Respondent violated the Mcare Act.

Respondent's second argument is that the seizure of his cash and assets precluded him from purchasing tail coverage and that this inability to purchase insurance must be considered by the Board in determining any sanction. However, this assertion by Respondent was not made part of the record and, thus, cannot be considered by the Board. It is well settled that evidence not placed on the record at the hearing cannot be considered. See, e.g., *Yi v. State Bd. of Veterinary Medicine*, 960 A.2d 864 (Pa. Commw. 2008) (holding the Board could not consider evidence not placed on the record at hearing); *Barran v. State Board of Medicine*, 670 A.2d 765 (Pa. Commw. 1996) (striking from the reproduced record letters not placed in evidence at the

time of the hearing).

Even assuming, *arguendo*, that the Board could consider Respondent's ability to purchase the coverage mandated by statue, as the Commonwealth noted: "the obligation to purchase medical professional liability insurance is mandated by the Mcare Act. . . There is no exception to this duty to purchase the requisite liability insurance. To hold otherwise would lead to absurd results and allow physicians to practice medicine without adequate medical professional liability insurance coverage." The law requires professional liability coverage (including tail coverage when necessary) without exception or excuse.

There are many examples of requirements in law which mandate the payment of fees or the procurement of insurance by individuals without regard to the means by which an individual meets that requirement. Medical professional liability insurance is no exception. In blunt terms, the law does not consider whether a medical professional can afford liability insurance or the reason for a proferred inability to afford insurance; the law only cares that the medical professional has liability insurance as a condition for practicing his profession. This is because the primary purpose of the law is to ensure the welfare of the public.

For the foregoing reasons, the Board also rejects Respondent's argument in regard to his inability to purchase tail coverage as provided by law.

The Board has a substantial interest in preventing licensees from causing harm to the public. In fact, the Board's mandate is to protect the public from practitioners who pose a risk to the public. In this case, the hearing examiner's determinations that Respondent violated the Mcare Act were based on substantial evidence and the hearing examiner properly considered all the evidence and determined that it is appropriate to suspend Respondent's license, indefinitely,

unless and until he complies with the law pertaining to the maintenance of medical professional liability insurance for the period in question. The Board agrees.

Accordingly, based upon the findings of fact, conclusions of law and discussion, the following order shall issue:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs	:	
	:	**Docket No. 0155-49-11**
v.	:	
	:	**File No. 11-49-01059**
Kermit Barron Gosnell, M.D., Respondent	:	

ORDER

NOW, this day 12 of July 2012, the State Board of medicine hereby **ADOPTS** the findings of fact, conclusions of law and discussion of the hearing examiner and the foregoing additional discussion addressing Applicant's brief for review and the Commonwealth's response to Respondent's brief for review and hereby **ORDERS** that, should the voluntarily surrendered license to practice medicine and surgery of Respondent Kermit Barron Gosnell, M.D., license no. MD009422E, be reinstated, renewed, reactivated or reissued to Respondent, said license then shall **IMMEDIATELY** be **INDEFINITELY SUSPENDED** until such time as Respondent complies with the requirements of the Medical care Availability and Reduction of Error (Mcare) Act, Act of March 20, 2002, P.L. 154, No. 13, *as amended*, 40 P.S. § 1303.101 - § 1303.1115, pertaining to the purchase and maintaining of medical professional liability insurance for the period of April 18, 2005 through March 17, 2010.

This order shall take effect immediately.

BY ORDER:

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

Katie True

KATIE TRUE,
COMMISSIONER

STATE BOARD OF MEDICINE

James W. Freeman MD

JAMES W. FREEMAN, M.D.
CHAIR

For Respondent:	William I. Arbuckle, III, Esquire THE MAZZA LAW GROUP, P.C. 3081 Enterprise Drive, Suite 2 State College, PA 16801-5923
For the Commonwealth:	Anita P. Shekletski, Esquire Commonwealth of Pennsylvania GOVERNOR'S OFFICE OF GENERAL COUNSEL Department of State P.O. Box 2649 Harrisburg, PA 17105-2649
Board Counsel:	Teresa A. Lazo, Esquire
Date of Mailing:	July 12, 2012

Attachment A

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania,	:	
Bureau of Professional and	:	
Occupational Affairs	:	
	:	**Docket No.** 0155-49-11
v.	:	**File No.** 11-49-01059
	:	
Kermit Barron Gosnell, M.D.,	:	
Respondent	:	

ADJUDICATION AND ORDER

Ruth D. Dunnewold
Hearing Examiner

Commonwealth of Pennsylvania
GOVERNOR'S OFFICE OF GENERAL COUNSEL
Department of State
P.O. Box 2649
Harrisburg, PA 17105-2649
(717) 772-2686

11/18/11

MAILER

HISTORY

This matter comes before a hearing examiner for the Department of State on an order to show cause filed February 8, 2011, alleging that Kermit Barron Gosnell, M.D. (Respondent) is subject to disciplinary action by the State Board of Medicine (Board) under the Medical Practice Act, Act of December 20, 1985, P.L. 457, No. 112 (Act), *as amended*, 63 P.S. § 422.1 – § 422.51a, the Medical Care Availability and Reduction of Error Act, Act of March 20, 2002, P.L. 154, No. 13 (Mcare Act or Act 13), *as amended*, 40 P.S. § 1303.101 – § 1303.1115, and the Act of July 2, 1993, P.L. 345, No. 48 (Act 48), *as amended,* 63 P.S. § 2201 – § 2207. The single count of the order to show cause alleges that Respondent violated the Mcare Act by failing to maintain professional liability insurance as required by the Mcare Act for the period April 18, 2005 through to March 17, 2010.

The Commonwealth personally served the order to show cause upon Respondent. The order to show cause directed Respondent to file an answer thereto within thirty days of its date, a period which expired on March 10, 2011. Respondent did not file an answer or otherwise respond to the allegations in the order to show cause within that timeframe, and on March 23, 2011, the Commonwealth filed a Motion to Enter Default and Deem Facts Admitted (MDFA). The MDFA was served upon Respondent on that same date, by first class mail, postage prepaid, at the same address at which service of the order to show cause had been personally made. When Respondent did not file an answer to either the order to show cause or the MDFA within the time frame established in the General Rules of Administrative Practice and Procedure (GRAPP), 1 Pa. Code § 31.1 *et seq.*, an Adjudication and Order which, among other things, granted the MDFA, was filed April 5, 2011.

However, on April 5, 2011, Respondent submitted via facsimile transmission[1] a Motion for Indefinite Continuance to File Response Pending Outcome of Criminal Proceedings, asserting that many of Respondent's records at his home and office had been seized by law enforcement officials pursuant to a search warrant executed April 3, 2010, rendering Respondent unable to adequately respond to the order to show cause. Respondent's Motion asked for an indefinite extension of time to file a response to the OSC pending the outcome of criminal proceedings against him in Philadelphia County or, in the event he would be released on bail, a minimum of 60 days to gather the necessary documents to respond. On April 6, 2011, the hearing examiner issued an Order Denying Respondent's Motion for Indefinite Continuance to File Response Pending Outcome of Criminal Prosecution.

Thereafter, on April 8, 2011, the Board on its own motion issued a Notice of Review, which established a briefing schedule. Respondent submitted via facsimile transmission his Brief in Opposition of Adjudication and Order on April 21, 2011,[2] and the Commonwealth filed its Reply Brief to Respondent's Brief in Opposition of Adjudication and Order on May 6, 2011. By Memorandum Order Vacating Adjudication and Remanding for Further Proceedings, the Board recognized as legally appropriate the prior procedural actions but granted Respondent the opportunity to answer the OSC and to allow both parties the ability to present evidence in the matter during a scheduled hearing. The Board further indicated that an indefinite continuance was not justified and that Respondent should be given a reasonable period of time in which to obtain his records or provide evidence satisfactory to the hearing examiner of his inability to do

[1]Respondent filed a hard copy original of the Motion for Indefinite Continuance to File Response Pending Outcome of Criminal Proceedings on April 7, 2011.
[2]Respondent filed a hard copy original of his Brief in Opposition of Adjudication and Order on April 28, 2011.

so, to file an answer, and to have the matter scheduled for hearing.

The hearing examiner issued a Case Management Order on July 15, 2011, granting Respondent 60 days, by close of business on September 13, 2011, in which to obtain the necessary records to file an answer to the order to show cause or to file satisfactory evidence of his inability to do so and to file an answer to the order to show cause. On September 12, 2011, Respondent filed a Response to Case Management Order and Request for Delay Pending Outcome of Criminal Prosecution, reiterating the fact that his records had been seized, curtailing his access to them, and again asking for an indefinite extension of time in which to obtain the necessary documents and file a response to the OSC. The Commonwealth, on September 22, 2011, filed a Motion to Enter Default and Deem Facts Admitted and Commonwealth's Reply to Respondent's Response to Case Management Order and Request for Delay Pending Outcome of Criminal Prosecution.

The hearing examiner denied Respondent's Request for Delay Pending Outcome of Criminal Prosecution by Order filed September 23, 2011. A Notice of Hearing dated September 30, 2011 scheduled the matter for hearing to occur on October 26, 2011. Thereafter, by Order filed October 5, 2011, the hearing examiner denied the Commonwealth's Motion to Enter Default and Deem Facts Admitted. Respondent submitted by facsimile transmission on October 12, 2011,[3] an Application for Subpoena, asking that a subpoena be issued compelling Respondent, who is incarcerated, to appear. The hearing examiner granted the Application for Subpoena on October 13, 2011, but the Commonwealth filed a Reply to Respondent's Application for Subpoena, on October 14, 2011. Respondent filed an Answer to Order to Show

[3]Respondent filed a hard copy original of the Application for Subpoena on October 13, 2011.

Cause and Request for Hearing on October 25, 2011.

Hearing occurred as scheduled on the following day. The Commonwealth was represented by Anita P. Shekletski, Esquire. Respondent was not present, due to his remaining incarcerated, but was represented by counsel, William I. Arbuckle, III, Esquire. At the conclusion of the hearing, Respondent's counsel indicated the desire to file a post-hearing brief, and a briefing scheduled was established, which was memorialized in an Order Establishing Briefing Schedule filed October 27, 2011, requiring that Respondent file his post-hearing brief no later than close of business on November 7, 2011 and that the Commonwealth file a response within 10 days of the date on which Respondent files his brief. The Notes of Testimony were filed November 4, 2011; Respondent's Post-Hearing Brief was submitted by facsimile transmission on November 8, 2011;[4] and the Commonwealth filed its Reply Brief on November 14, 2011, closing the record.

[4]Respondent filed a hard copy original of his Post-Hearing Brief on November 9, 2011.

FINDINGS OF FACT

1. Respondent was issued a license to practice medicine in the Commonwealth of Pennsylvania, license no. MD009422E, on July 1, 1967. Exhibit C-1 at paragraphs 1 and 3; Exhibit C-2 at paragraphs 1 and 3.

2. By Consent Agreement and Order which the Board adopted February 22, 2011, Respondent voluntarily surrendered his license while a criminal case is pending against him in the Philadelphia County Court of Common Pleas based on charges of murder and drug law violations relating to his practice of medicine. Official notice of Board records at Docket No. 1647-49-10.[5]

3. At all pertinent times, Respondent held a license to practice as a medical physician and surgeon in the Commonwealth of Pennsylvania. Exhibit C-1 at paragraph 4; Exhibit C-2 at paragraph 4.

4. Respondent's last known address on file with the Board is 3801 Lancaster Avenue, Philadelphia, PA 19104. Official notice of Board records.[6]

5. A health care provider providing health care services in the Commonwealth is required to purchase medical professional liability insurance from an insurer which is licensed or approved by the Department of Insurance, or shall provide self-insurance. Mcare Act at §711(a), 40 P.S. § 1303.711(a); Notes of Testimony (NT) at 14.

6. "Medical professional liability insurance" is insurance against liability on the part of a health care provider arising out of any tort or breach of contract causing injury or death

[5]At the hearing, the parties agreed that the hearing examiner could take official notice of the status of Respondent's license with the Board. Notes of Testimony (NT) at 41.
[6]At the hearing, the parties agreed that the hearing examiner could take official notice of Respondent's address on file with the Board. NT at 32 – 33.

resulting from the furnishing of medical services which were or should have been provided. Mcare Act at § 702, 40 P.S. § 1303.702.

7. "Claims-made" is a type of medical professional liability insurance that insures those claims made or reported during a period which is insured and excludes coverage for a claim reported subsequent to the period even if the claim resulted from an occurrence during the period which was insured. Mcare Act at § 702, 40 P.S. § 1303.702; NT at 15.

8. Under a claims-made policy, the medical professional liability coverage ceases when the policy ceases, so for a claim to be covered, it must come in while the claims-made policy is in effect. NT at 15.

9. Tail coverage, also known as an extended reporting endorsement, is a type of medical professional liability coverage which will provide coverage for a claim that is made, after the claims-made policy terminates, for incidents that occurred while the claims-made coverage was in effect. NT at 15 – 16.

10. The purpose of tail coverage is to make sure that there is liability coverage in place after the claims-made policy terminates. NT at 29.

11. Respondent had claims-made coverage for the period from April 18, 2005 until March 17, 2010. NT at 23, 25.

12. When Respondent's claims-made coverage terminated on March 17, 2010, Respondent was no longer covered for any claims that would come in. NT at 24, 25.

13. Therefore, Respondent needed tail coverage to provide coverage for any claims made thereafter for the period in which he had maintained claims-made insurance. NT at 15, 16, 23 – 24.

14. A licensee cannot purchase tail coverage until the claims-made policy is about to terminate or has terminated. NT at 28.

15. The Department of Insurance, Mcare Fund ("Mcare Fund" or "Fund"), is responsible for ensuring that physicians are in compliance with the mandatory insurance requirements in the Commonwealth, for notifying noncompliant physicians, and for notifying the physicians' licensing agencies, such as the State Board of Medicine, of the physicians' noncompliance. NT at 11, 12, 13.

16. A physician has 60 days to purchase tail coverage after his claims-made policy expires. NT at 26.

17. The physician's insurance carrier, who is providing the tail coverage, has 60 days to report the coverage to the Fund. *Id.*

18. The Fund, internally, then allots 30 days to put that information into its system, meaning that the Fund does not know, until approximately 150 days after a claims-made policy terminates, whether the physician has purchased tail coverage. *Id.*

19. When the Fund notifies a physician that according to the Fund's records, he is noncompliant, the process involves two letters. NT at 22.

20. The first letter notifies the physician that he has a potential tail coverage issue, in that, if he did, in fact, purchase the required tail insurance, he needs to contact his carrier because the Fund has no record of it. *Id.*

21. The Fund sent such a first letter to Respondent dated August 31, 2010. Exhibit C-5; NT at 21 – 22.

22. The Fund had no contact from Respondent or from anyone on his behalf for the purpose of providing proof of compliance with the medical professional liability insurance requirements of the Mcare Act. NT at 26.

23. When the Fund does not receive a response to its first letter, or receive proof of the required insurance coverage for the physician, the Fund sends out a second letter. NT at 22.

24. By such a second letter, dated October 29, 2010, the Fund notified Respondent that Respondent was not in compliance with the insurance provisions of Act 13 and that the Fund would be certifying Respondent's noncompliance to his licensing agency for his failure to purchase tail coverage. Exhibit C-3; NT at 18, 19.

25. By copying the second letter to Lori Foster Doudrick, a paralegal at the Department of State, Bureau of Professional and Occupational Affairs, whose job responsibilities include attempting to bring noncompliant physicians into compliance with the Mcare Act, the Fund certified to the Board that Respondent was noncompliant. Exhibit C-3; NT at 19, 33 – 34.

26. On or about February 7, 2011, Ms. Doudrick received a letter from the Fund confirming that Respondent remained noncompliant with the insurance provisions of Act 13. Exhibit C-4; NT at 20 – 21, 36.

27. As of the date of the hearing in this matter, the Fund had not had any contact from Respondent or from anyone on his behalf for the purpose of providing proof of compliance with the medical professional liability insurance requirements of the Mcare Act. NT at 26.

28. From July 1967 until February 10, 2011, Respondent practiced in the Commonwealth of Pennsylvania. Exhibit C-1 at paragraphs 1, 3, 4 and 10; Exhibit C-2 at paragraphs 1, 3, 4, 10.

29. Since March 17, 2010, Respondent has had no medical professional liability insurance in place to cover any tort or breach of contract causing injury or death resulting from his furnishing of medical services during the period from April 18, 2005 to March 17, 2010. Exhibit C-2 at attached Exhibit A; Exhibit C-3; Exhibit C-4; Exhibit C-5; NT at 23, 24, 25.

30. Respondent was served with the order to show cause and all subsequent pleadings, orders and notices filed of record in this matter and was represented by counsel at the hearing. Exhibit C-1; Exhibit C-2; NT at 6 and *passim*.

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter. Findings of Fact 1 – 3, 28.

2. Respondent has been afforded reasonable notice of the charges against him and an opportunity to be heard in this proceeding, in accordance with the Administrative Agency Law, 2 Pa. C.S. § 504. Finding of Fact 30.

3. Respondent violated the Mcare Act in that Respondent failed to maintain professional liability insurance as required by the Mcare Act for the period of April 18, 2005 through to March 17, 2010. Findings of Fact 5 – 29.

4. Respondent is subject to discipline under the Mcare Act at § 711(c) and § 908, 40 P.S. § 1303.711(c) and § 1303.908, because he failed to maintain professional liability insurance as required by the Mcare Act. Findings of Fact 5 – 29.

DISCUSSION

Violation

This action is brought under the Mcare Act at § 711(c), 40 P.S. § 1303.711(c), which provides as follows:

* * *

> (c) **Failure to provide proof of insurance.**—If a health care provider fails to submit the proof of insurance or self-insurance required by subsection (b), the department shall, after providing the health care provider with notice, notify the health care provider's licensing authority. *A health care provider's license shall be suspended or revoked by its licensure board or agency if the health care provider fails to comply with any of the provisions of this chapter.*

* * *

(Emphasis added). The "provisions of this chapter" include the requirement that a health care provider providing health care services in the Commonwealth shall purchase "medical professional liability insurance" from an insurer which is licensed or approved by the Department of Insurance. Mcare Act at § 711(a), 40 P.S. § 1303.711(a). The order to show cause charges that Respondent failed to maintain professional liability insurance, as required by the Mcare Act, for the period April 18, 2005 through to March 17, 2010.

Respondent argues that he had medical professional liability insurance in effect *during* the period in question, so he cannot be found in violation of the Mcare Act as charged in the order to show cause. However, in making that argument, Respondent mischaracterizes the allegations. Respondent was not charged with failing to have the requisite insurance in effect *during* the period in question. Rather, he was charged with failing to maintain the requisite insurance *for* the period in question, based on the fact that he allowed his claims-made policy, which was clearly in effect *during* the period in question, to terminate, thus ending any professional liability insurance coverage *for* that same period.

In support of his argument, Respondent asserts that the statute does not require the purchase of tail coverage after a claims-made policy terminates, and maintains that because he

had a claims-made policy in effect from April 18, 2005 through March 17, 2010, he met the requirements of the Mcare Act. In considering this argument, the definition of the term "medical professional liability insurance" is vital. The Mcare Act defines the term as

> insurance against liability on the part of a health care provider arising out of *any* tort or breach of contract causing injury or death resulting from the furnishing of medical services which were or should have been provided.

Mcare Act at § 702, 40 P.S. § 1303.702 (emphasis added). This is a broad definition which excludes nothing: "medical professional liability insurance" is insurance against liability arising out of *any* tort or breach of contract.

If Respondent's argument were to succeed, this term's definition would have to be read in a more limited fashion, because it would be defined as insurance against liability for only those torts or breaches of contract for which claims are filed during the term of a claims-made policy. Such a gloss on the definition ignores the term "any," which in this context means "without limit." *See* WEBSTER'S NEW WORLD DICTIONARY 62 (3d Coll. Ed. 1994). And ignoring that simple term violates the rules of statutory construction, which presume that the legislature intended every word of a statute to have effect. 1 Pa. C.S.A. § 1921(a); 1 Pa. C.S.A. § 1922(2); *c.f. Habecker v. Nationwide Ins. Co,* 445 A.2d 1222, 1226 (Pa. Super. 1982) (legislature is presumed to have intended to avoid mere surplusage in words, sentences and provisions of its law and courts must therefore construe a statute, if possible, so as to give effect to every word). This is the first reason Respondent's argument that, the definition should be limited to claims-made insurance policies, cannot succeed.

This construction of the Mcare Act is also supported by the presence in the Mcare Act of § 742, 40 P.S. § 1303.742, which provides:

> The commissioner shall not approve a medical professional liability insurance policy written on a "claims made" basis by any insurer doing business in this Commonwealth unless the insurer shall guarantee to the commissioner the continued availability of suitable liability protection for a health care provider subsequent to the discontinuance of professional practice by the health care provider or the termination of the insurance policy by the insurer or the health

> care provider for so long as there is a reasonable probability of a claim for injury for which the health care provider may be held liable.

This provision, in essence, requires providers of claims-made medical professional liability insurance to offer tail coverage to health care providers who discontinue their practice or who terminate their claims-made insurance policies. It follows logically and reasonably that insurers would not be required to make such insurance available if health care providers were not required by the definitions and other provisions of the Mcare Act to purchase it. Thus, this provision is an additional indicator of the legislative intent that health care providers must purchase tail coverage upon expiration or termination of a claims-made policy in order to be in compliance with the requirement that they purchase "medical professional liability insurance" as defined in the Mcare Act, and this is an additional reason Respondent's argument fails.

Additionally, a primary purpose of the statutory requirement that physicians purchase medical professional liability insurance is to insure that persons injured as a result of medical malpractice may receive reasonable compensation for those claims. *Meier v. Maleski*, 648 A.2d 595, 598 n. 3 (Pa. Cmwlth. 1994); *see also The Milton S. Hershey Medical Center of Pennsylvania State University v. Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund*, 788 A.2d 1071, 1074 n. 3 (Pa. Cmwlth. 2001), *aff'd The Milton S. Hershey Medical Center of the Pennsylvania State University v. Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund,* 821 A.2d 1205 (Pa. 2003). While those cases interpreted the predecessor to the Mcare Act, which was the Health Care Services Malpractice Act (the HCSMA), Act of October 15, 1975, P.L. 390, No. 111, *as amended*, 40 P.S. § 1301.701 *et seq.*, the Mcare Act states a similar purpose, both at § 102(4), 40 P.S. § 1303.102(4), which reads as follows:

> A person who has sustained injury or death as a result of medical negligence by a health care provider must be afforded a prompt determination and fair compensation. . .

and at § 502, 40 P.S. § 1303.502, which states in pertinent part:

> The General Assembly finds and declares that it is the purpose of this chapter to ensure a fair legal process and reasonable compensation for persons injured due to medical negligence in this Commonwealth. . .

Therefore, to interpret the broad definition found in the Mcare Act more narrowly, as Respondent proposes, would be to ignore the plain meaning of the statute and the express intent of the General Assembly, again violating the rules of statutory construction. 1 Pa. C.S.A. § 1903(a); 1 Pa. C.S.A. § 1921(a).

Also, Jeffrey Nell, the Mcare Fund's representative, testified to the Fund's interpretation of the Mcare Act, which is that a physician is required to have coverage for any claim that might be filed against him, meaning a physician must purchase tail coverage when a claims-made policy terminates. In light of the plain meaning of the above definition, that position is completely supportable, because when a claims-made policy terminates, the physician no longer has any insurance against liability for claims – i.e. torts or breaches of contract – that arose during the coverage of the claims-made policy, but which are reported after it terminates. By purchasing tail coverage, the physician continues to have coverage for that past period, thus affording the legislatively-intended fair compensation to a person who has sustained injury or death as a result of the physician's medical negligence. By failing to purchase it, the physician no longer has "medical professional liability insurance" in place, as it is defined in the Mcare Act, and he has, therefore, failed to comply with § 711, 40 P.S. § 1303.711, subjecting himself to the suspension or revocation of his license, as mandated in § 711(c), 40 P.S. § 1303.711(c).

This interpretation is also consistent with prior Pennsylvania appellate decisions interpreting the predecessor act, the HCSMA. Respondent cites the *dissenting* opinion in *Paternaster v. Lee*, 863 A.2d 487 (Pa. 2004), arguing that it supports his proposition that there is no requirement in the law that a physician purchase tail coverage after his claims-made policy has expired. However, a dissenting opinion, as the Commonwealth aptly points out, is not authority upon which a party may rely. *Tate Liquor License Case*, 173 A.2d 657 (Pa. Super.

1961). The *Paternaster* decision discussed, among other things, the Insurance Department's regulation, 31 Pa. Code § 242.2, which states that

> in the case of a claims made policy permitted under sections 103 and 807 of the act (40 P. S. §§ 1301.103 and 1301.807), the insurance requirements of the act require purchase of the reporting endorsement (that is, tail coverage) or prior acts coverage or its substantial equivalent by the health care provider, upon cancellation or termination of the claims made policy.

31 Pa. Code § 242.2. The appellant in *Paternaster* challenged that regulation as beyond the authority conferred on the CAT Fund (the predecessor to the Mcare Fund) director by the HCSMA. However, the court's decision stated that the regulations requiring health care providers with claims-made policies to maintain primary insurance after the claims-made policies expire by purchasing prior acts coverage (tail coverage) "are surely reasonable and consistent with the [HCSMA]." *Paternaster*, 863 A.2d at 494.

Indeed, the subject regulation, 31 Pa. Code § 242.2, remains effective under the Mcare Act because § 5107 of the Mcare Act provides, in pertinent part, as follows:

> **Section 5107. Continuation.**
>
> (a) Orders and regulations.--Orders and regulations which were issued or promulgated under the former act of October 15, 1975 (P.L. 390, No. 111), known as the Health Care Services Malpractice Act, and which are in effect on the effective date of this section shall remain applicable and in full force and effect until modified under this act.
>
> * * *

Since the regulation at 31 Pa. Code § 242.2 is consistent with the HCSMA and remains in effect despite the repeal of HCSMA and its replacement by the Mcare Act, our interpretation of the broad definition in the Mcare Act of "medical professional liability insurance" as including the requirement that a physician must purchase tail coverage upon the termination of a claims-made policy is, similarly, consistent with the Mcare Act.

The court in *Gingerlowski v. Com., Ins. Dept.*, 961 A.2d 237 (Pa. Cmwlth. 2008), made a similar determination, citing *Paternaster* for the proposition that CAT Fund regulations

promulgated under the HCSMA legally require a physician to maintain tail coverage upon cancellation of his claims-made policy. *Gingerlowski*, 961 A.2d at 244. Furthermore, the court stated that

> [a] health care provider must purchase tail coverage or its substantial equivalent on the termination of a claims made policy or he will not be eligible for Fund indemnification and defense of claims arising after the termination of the claims made policy. 31 Pa. Code §§242.2, 242.7(a)(2) and 242.17(d)(2); *Paternaster*. Otherwise, a provider would be without basic coverage insurance in violation of Section 701 of the Malpractice Act, *formerly* 40 P.S. §1301.701 [the language of which was analogous, though not identical, to the Mcare Act language at § 711, 40 P.S. § 1303.711].

Gingerlowski, 961 A.2d at 243 (emphasis added). While *Paternaster* and *Gingerlowski* addressed the issue of whether a physician would be covered by the CAT Fund's excess liability provisions, a separate issue from those under consideration in this matter, the language quoted above indicates that in both cases, the courts determined that basic coverage insurance under the HCSMA required the holder of a claims-made policy to purchase tail coverage upon termination of a claims-made policy. To interpret the definition in the Mcare Act as including that requirement, then, is consistent both with case law interpreting the HCSMA and with the language and intent of the Mcare Act. Respondent's argument to the contrary flies in the face of the rules of statutory construction, the expressed intent of the General Assembly, and prior case law construing the analogous predecessor legislation, so it must be rejected.

Nor, despite Respondent's argument to the contrary, does the physician's ceasing practice in the Commonwealth eliminate his responsibility to purchase medical professional liability insurance as fully defined in the Mcare Act. Ceasing practice in the Commonwealth certainly relieves the physician of responsibility for purchasing such insurance for any time frame in which he is not practicing, but it does not relieve him of the responsibility of purchasing insurance which covers the time frame during which he *was* practicing. Once again, any other interpretation ignores the plain meaning of the statute and the express intent of the General Assembly; the need for tail coverage simply cannot be separated from the termination of a

claims-made policy. Separating the two results in a lack of coverage for torts and breaches of contract that occurred during the term of the claims-made policy but which were not reported until after that policy terminated. Therefore, both are necessary for a physician to have purchased "medical professional liability insurance" as it is defined in the Mcare Act.

Finally, returning to Respondent's argument that he had the requisite insurance *during* the period in question, in that he had a claims-made policy in effect while he practiced from April 18, 2005, through March 17, 2010, the foregoing discussion makes it clear that the question at issue is not whether he had a policy in effect while he was practicing. The question, given the Mcare Act definition discussed throughout this decision, is whether Respondent purchased medical professional liability insurance to insure against liability on his part arising out of "*any* tort or breach of contract causing injury or death resulting from the furnishing of medical services which were or should have been provided." In this case, the facts clearly indicate that Respondent made no such purchase after his claims-made policy expired; he had a policy *during* the period in question but he did not have a policy *for* the period in question after that other policy ceased. That means he failed to maintain medical professional liability insurance after his claims-made policy terminated. Therefore, the Commonwealth has met its burden of proof[7] as to the allegations in the order to show cause.

Sanction

The Board has a duty to protect the health and safety of the public. Under professional licensing statutes including the Mcare Act and the Act, the Board is charged with the

[7]The degree of proof required to establish a case before an administrative tribunal in an action of this nature is a preponderance of the evidence. *Lansberry v. Pennsylvania Public Utility Commission*, 578 A.2d 600, 602 (Pa. Cmwlth. 1990). A preponderance of the evidence is generally understood to mean that the evidence demonstrates a fact is more likely to be true than not to be true, or if the burden were viewed as a balance scale, the evidence in support of the Commonwealth's case must weigh slightly more than the opposing evidence. *Se-Ling Hosiery, Inc. v. Margulies*, 70 A.2d 854, 856 (Pa. 1949). The Commonwealth therefore has the burden of proving the charges against Respondent with evidence that is substantial and legally credible, not by mere "suspicion" or by only a "scintilla" of evidence. *Lansberry*, 578 A.2d at 602.

responsibility and authority to oversee the profession and to regulate and license professionals to protect the public health and safety. *Barran v. State Board of Medicine,* 670 A.2d 765, 767 (Pa. Cmwlth. 1996), *appeal denied* 679 A.2d 230 (Pa. 1996). Based on the findings of fact and discussion above, Respondent is subject to the suspension or revocation of his license under the Mcare Act at § 711(c), 40 P.S. § 1303.711(c). Additionally, the Mcare Act, at § 908, 40 P.S. § 1303.908, authorizes the Board to impose a civil penalty of up to $10,000 on any current licensee who violates the Act,[8] and the Act authorizes the Board, at § 39, § 41 and § 42, 63 P.S. § 422.39 – § 422.42, to impose a civil penalty upon any current licensee who violates any provision of the Act,[9] to impose disciplinary or corrective measures on a board-regulated practitioner for any of several enumerated reasons, including violation of a regulation,[10] and to impose any one of a number of possible sanctions if the Board deems a sanction to be appropriate.[11] In this case,

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[8] **§ 908. Licensure board-imposed civil penalty.**

In addition to any other civil remedy or criminal penalty provided for in this act, the act of December 20, 1985 (P.L.457, No. 112), known as the Medical Practice Act of 1985, or the act of October 5, 1978 (P.L.1109, No. 261), known as the Osteopathic Medical Practice Act, the State Board of Medicine and the State Board of Osteopathic Medicine, by a vote of the majority of the maximum number of the authorized membership of each board as provided by law or by a vote of the majority of the duly qualified and confirmed membership or a minimum of five members, whichever is greater, may levy a civil penalty of up to $10,000 on any current licensee who violates any provision of this act, the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act or on any person who practices medicine or osteopathic medicine without being properly licensed to do so under the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act. The boards shall levy this penalty only after affording the accused party the opportunity for a hearing as provided in 2 Pa. C.S. (relating to administrative law and procedure).

[9] **§ 39. Penalties.**

* * *

(b) **Civil penalties.**—In addition to any other civil remedy or criminal penalty provided for in this act, the board . . . may levy a civil penalty of up to $1,000 on any current licensee who violates any provision of this act . . .

* * *

[10] **§ 41. Reasons for refusal, revocation, or suspension of license.**

The board shall have authority to impose disciplinary or corrective measures on a board-regulated practitioner for any or all of the following reasons:

* * *

[11] **§ 42. Types of corrective action.**

(footnote continued on next page)

however, the order to show cause specifically charged Respondent under the Mcare Act, rather than under any provision of the Act, so the Mcare Act serves as the basis for suspending or revoking Respondent's license in this matter. In fact, under the language of the provision charged, which provides that the licensing board *shall* suspend or revoke the license of a health care provider who fails to comply with any of the provisions of the Mcare Act, the Board has no discretion; it must suspend or revoke the physician's license for failure to carry medical professional liability insurance. *See Slawek v. Com., State Bd. of Medical Educ. and Licensure*, 586 A.2d 362, 364 (Pa. 1991) (where statute provides that a physician's failure to carry medical malpractice insurance "shall result in the suspension or revocation of the health care provider's license by the licensure board," and the board revokes the license, the board did not abuse its discretion because it had no discretion). The General Assembly, in requiring that health care providers who are providing health care services in the Commonwealth shall purchase and maintain medical professional liability insurance, has imposed a requirement which protects the public. Respondent disregarded that requirement after his claims-made policy terminated.

(a) **Authorized actions.**—When the board is empowered to take disciplinary or corrective action against a board-regulated practitioner under the provisions of this act or pursuant to other statutory authority, the board may:

(1) Deny the application for a license, certificate or any other privilege granted by the board.

(2) Administer a public reprimand with or without probation.

(3) Revoke, suspend, limit or otherwise restrict a license or certificate.

(4) Require the board-regulated practitioner to submit to the care, counseling or treatment of a physician or a psychologist designated by the board.

(5) Require the board-regulated practitioner to take refresher educational courses.

(6) Stay enforcement of any suspension, other than that imposed in accordance with section 40, and place a board-regulated practitioner on probation with the right to vacate the probationary order for noncompliance.

(7) Impose a monetary penalty in accordance with this act.

Absent any mitigating evidence in this case, there is no basis for proceeding lightly in the imposition of a sanction. Respondent has done a disservice to the citizens of Pennsylvania by not maintaining medical professional liability insurance. Under the circumstances, the Mcare Act authorizes the revocation or suspension of Respondent's license, and it is appropriate to indefinitely suspend Respondent's license unless and until he complies with the law pertaining to the maintaining of medical professional liability insurance for the period in question. Accordingly, based upon the above findings of fact, conclusions of law and discussion, and in the absence of mitigating evidence, the following order shall issue:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs	:	
	:	**Docket No. 0155-49-11**
v.	:	**File No. 11-49-01059**
Kermit Barron Gosnell, M.D., Respondent	:	

ORDER

AND NOW, this 18th day of **November, 2011**, upon consideration of the foregoing findings of fact, conclusions of law and discussion, it is hereby **ORDERED** that, should the voluntarily surrendered license to practice medicine and surgery of Respondent Kermit Barron Gosnell, M.D., license no. MD009422E, be reinstated, renewed, reactivated or reissued to Respondent, said license then shall **IMMEDIATELY** be **INDEFINITELY SUSPENDED** until such time as Respondent complies with the requirements of the Medical Care Availability and Reduction of Error (Mcare) Act, Act of March 20, 2002, P.L. 154, No. 13, *as amended*, 40 P.S. § 1303.101 – § 1303.1115, pertaining to the purchase and maintaining of medical professional liability insurance for the period of April 18, 2005 through March 17, 2010.

This order shall take effect 20 days from the date of mailing unless otherwise ordered by the State Board of Medicine.

BY ORDER:

Ruth D. Dunnewold
Hearing Examiner

For the Commonwealth: Anita P. Shekletski, Esquire
GOVERNOR'S OFFICE OF GENERAL COUNSEL
DEPARTMENT OF STATE OFFICE OF CHIEF COUNSEL

PROSECUTION DIVISION
P.O. Box 2649
Harrisburg, PA 17105-2649

For Respondent:

William I. Arbuckle, III, Esquire
THE MAZZA LAW GROUP, P.C.
3081 Enterprise Drive, Suite 2
State College, PA 16801-5923

Date of Mailing: November 18, 2011

(Medicine)

NOTICE

REHEARING AND/OR RECONSIDERATION BY HEARING EXAMINER

A party may file an application to the hearing examiner for rehearing or reconsideration within 15 days of the mailing date of this adjudication and order. The application must be captioned *"Application for Rehearing"*, *"Application for Reconsideration"*, or *"Application for Rehearing or Reconsideration"*. It must state specifically and concisely, in numbered paragraphs, the grounds relied upon in seeking rehearing or reconsideration, including any alleged error in the adjudication. If the adjudication is sought to be vacated, reversed, or modified by reason of matters that have arisen since the hearing and decision, the matters relied upon by the petitioner must be set forth in the application.

APPEAL TO BOARD

An application to the State Board of Medicine for review of the hearing examiner's adjudication and order must be filed by a party within 20 days of the date of mailing of this adjudication and order. The application must be captioned *"Application for Review"*. It must state specifically and concisely, in numbered paragraphs, the grounds relied upon in seeking the Board's review of the hearing examiner's decision, including any alleged error in the adjudication. Within an application for review a party may request that the Board hear additional argument and take additional evidence.

An application to the Board to review the hearing examiner's decision may be filed irrespective of whether an application to the hearing examiner for rehearing or reconsideration is filed.

STAY OF HEARING EXAMINER'S ORDER

Neither the filing of an application for rehearing and/or reconsideration nor the filing of an application for review operates as a stay of the hearing examiner's order. To seek a stay of the hearing examiner's order, the party must file an application for stay directed to the Board.

FILING AND SERVICE

An original and three (3) copies of all applications shall be filed with:

Prothonotary
P.O. Box 2649
Harrisburg, PA 17105-2649

A copy of all applications must also be served on all parties.

Applications must be received for filing by the Prothonotary within the time limits specified. The date of receipt at the office of Prothonotary, and not the date of deposit in the mail, is determinative. The filing of an application for rehearing and/or reconsideration does not extend, or in any other manner affect, the time period in which an application for review may be filed.

NOTICE

The attached Adjudication and Order represents the final agency decision in this matter. It may be appealed to the Commonwealth Court of Pennsylvania by the filing of a Petition for Review with that Court within 30 days after the entry of the order in accordance with the Pennsylvania Rules of Appellate Procedure. See Chapter 15 of the Pennsylvania Rules of Appellate Procedure entitled "Judicial Review of Governmental Determinations," Pa. R.A.P 1501 – 1561. Please note: An order is entered on the date it is mailed. If you take an appeal to the Commonwealth Court, you must serve the Board with a copy of your Petition for Review. The agency contact for receiving service of such an appeal is:

Board Counsel
P.O. Box 2649
Harrisburg, PA 17105-2649

The name of the individual Board Counsel is identified on the Order page of the Adjudication and Order.