New York State Department of Health

Board for Professional Medical Conduct

2007 Annual Report

Office of Professional Medical Conduct
New York State Department of Health

433 River Street, Suite 303
Troy, NY 12180-2299

Main Number: 518-402-0836
Complaints/Inquiries: 1-800-663-6114
E-mail Inquiries: opmc@health.state.ny.us
Physician Information: www.nydoctorprofile.com *or* www.nyhealth.gov

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Board for Professional Medical Conduct
2007 Annual Report

Table of Contents

Board for Professional Medical Conduct

ANNUAL REPORT
2007

General Program Information

Board for Professional Medical Conduct

The State Board for Professional Medical Conduct (Board) was created by the New York State Legislature in 1976 and, with the Department of Health's Office of Professional Medical Conduct (OPMC), administers the state's physician discipline program. Its mission is to protect the public from medical negligence, incompetence and illegal or unethical practice by physicians. (In this report, when using the term physician, it refers to licensed medical doctors (MDs), doctors of osteopathy (DOs), and licensed, certified physician assistants and specialist assistants.) The physician discipline program is governed by two statutes. The process is described in Public Health Law Section 230. The definitions of misconduct are found in Sections 6530 and 6531 of the Education Law.

Public Health Law (PHL), Section 230(14) states:

> *The Board shall prepare an annual report for the legislature, the governor and other executive offices, the medical profession, medical professional societies, consumer agencies and other interested persons.*

In 1976, the state Legislature established the authority for the physician discipline program within the Department of Health. The Board became responsible for investigating complaints, conducting hearings and recommending disciplinary actions to the State Education Department. The State Education Department and its governing body, the Board of Regents, were responsible for determining final actions in all physician discipline cases.

In 1991, the Department of Health assumed full disciplinary authority, including the revocation of licenses, for physicians, physician assistants and specialist assistants. The Board for Professional Medical Conduct was granted sole responsibility for determining final administrative actions in all physician, physician assistant and specialist assistant discipline cases. All other health care professionals (e.g., nurses, dentists, podiatrists, etc.) continue to be licensed and disciplined by the State Education Department.

The Board is comprised of physician and non-physician lay members. Physician members are appointed by the Commissioner of Health with recommendations for membership received largely from medical and professional societies. The Commissioner of Health, with the approval of the Governor, appoints lay members of

the Board. By law, the Board of Regents appoints 20 percent of the Board's membership. At the end of 2007, the Board's membership was comprised of 113 physicians (representing 24 different medical specialties) and 45 lay members including six physician assistants.

In disciplinary matters, Board members serve on committees consisting of two physicians and one lay member, who are appointed by the Board Chair. Disciplinary committees include investigation, hearing and license restoration. The Administrative Review Board (ARB) is a standing committee consisting of three physicians and two lay members. Board members also serve on a variety of committees that address procedural and emerging policy issues.

Office of Professional Medical Conduct

The Office of Professional Medical Conduct (OPMC) provides staff to carry out the objectives of the Board. The OPMC's mission is to protect the public through the investigation and, when necessary, the prosecution of professional misconduct issues involving physicians. The OPMC also monitors physicians when required as a result of a Board action. Through its investigative and monitoring activities, the OPMC strives to deter medical misconduct and promote and preserve the highest standards of medical practice.

The OPMC has a central office in Troy, New York and six field offices (Troy, Buffalo, Rochester, Syracuse, New York City and New Rochelle).

The OPMC:

- Investigates all complaints and, with assistance of counsel, prosecutes physicians formally charged with misconduct;

- Monitors physicians whose licenses have been restored following a temporary surrender due to incapacity by drugs, alcohol or mental impairment;

- Monitors physicians placed on probation;

- Oversees the contract with the Medical Society of the State of New York's Committee for Physician Health (CPH) – a non-disciplinary program to identify, refer to treatment and monitor impaired physicians; and

- Supports the activities of the Board, including managing the appointment process, training, assisting with committee work and policy development, recruitment of medical experts and coordinating the canvass procedures for approximately 103 hearing panels that are convened annually.

Overview of New York's Medical Conduct Process

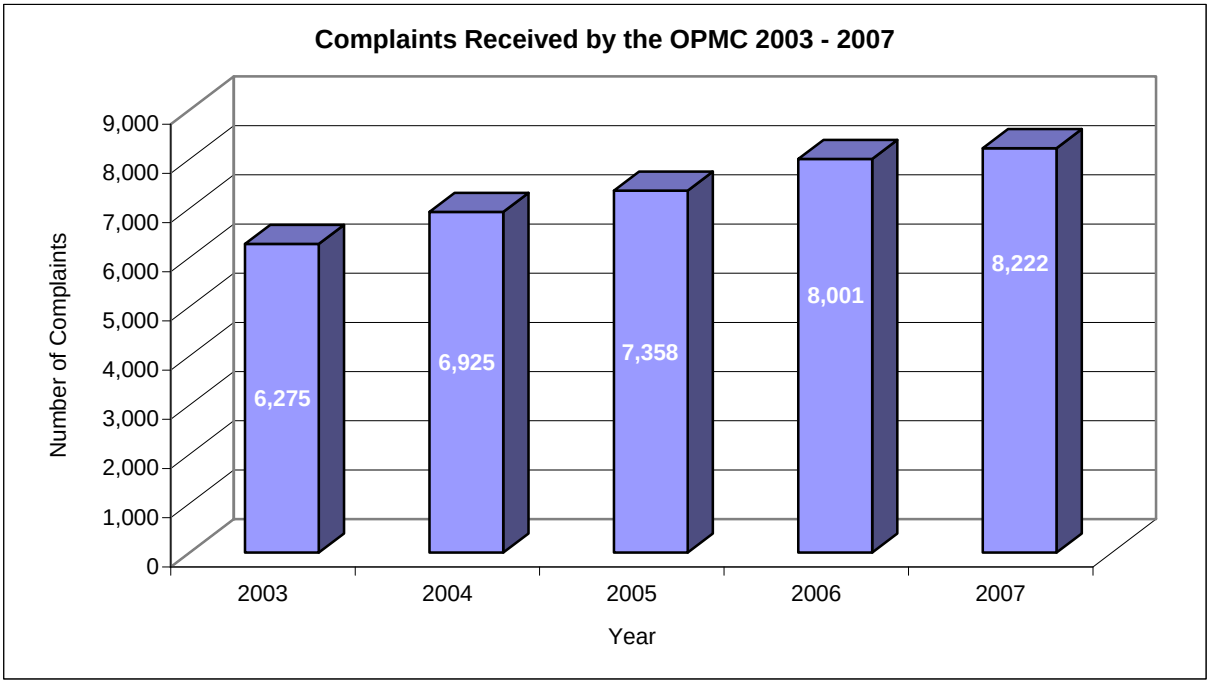
The OPMC and the Board administer the State's physician discipline process. The process involves the receipt and review of complaints, the investigation of allegations of misconduct and the prosecution of cases in which the evidence supports the presence of misconduct. Throughout the process, specific protocols are followed to ensure thorough, appropriate investigations and findings. Just as importantly, the process ensures appropriate due process for the physician under review.

Complaints

The OPMC is required by New York State Public Health Law Section 230(10) to investigate every complaint it receives. Complaints come from many sources: patients, their families and friends, health care professionals, health care facilities and other individuals or organizations. Complaints also may be opened as a result of a report in the media or a referral from another government agency.

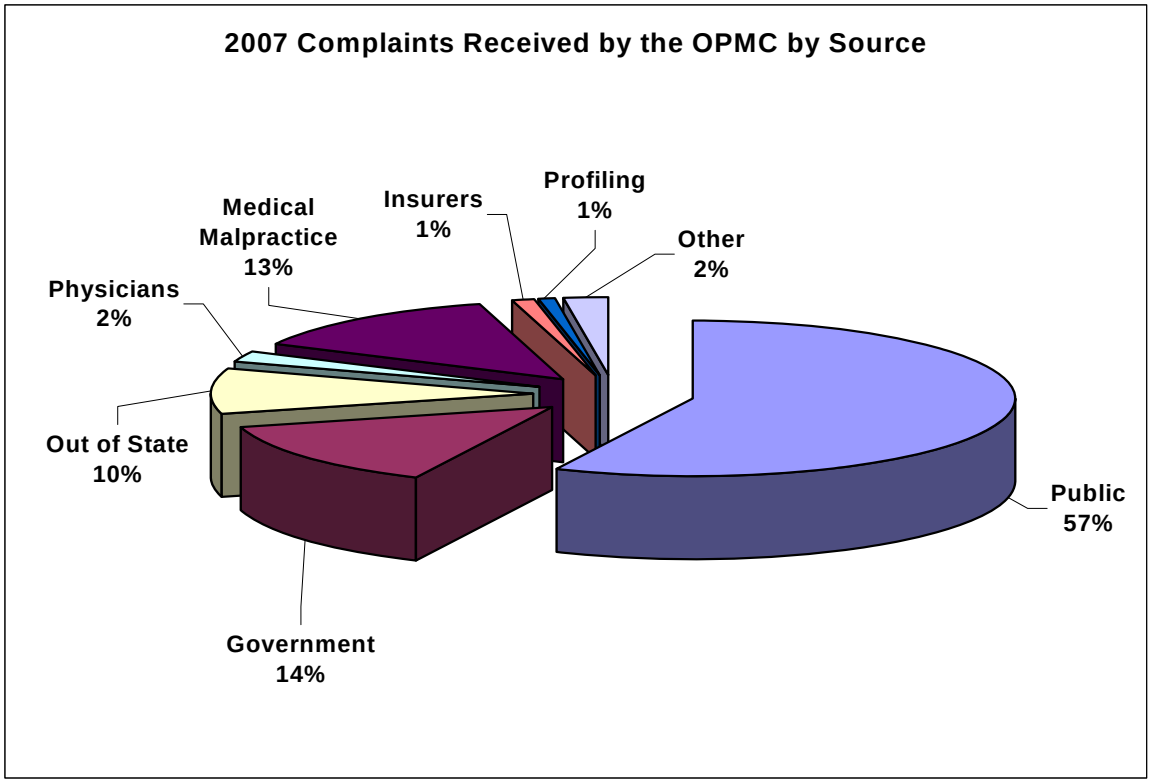
In 2007, OPMC received 8,222 complaints, compared to 8,001 in 2006. The 2007 volume is 31 percent higher than in 2003, when 6,275 complaints were received (see Figure 1). About 57 percent of the 8,222 complaints received came from the public (see Figure 2).

Figure 1



Source: The Office of Professional Medical Conduct

Figure 2



Source: The Office of Professional Medical Conduct

Every complaint is reviewed to determine a) if the subject of the complaint is a physician (thereby falling under the OPMC's jurisdiction), and b) if the allegation, if found true, would be medical misconduct. Many complaints fail to meet one or both of these thresholds, such as when the allegation is a billing dispute or when the complaint is related to a health care professional other than a physician.

In these instances, the case is closed administratively and the physician is not made aware of the complaint. The OPMC will make referrals to other agencies as appropriate.

Investigations

When OPMC commences an investigation, the physician under review is notified either by letter or through a telephone call. A letter requesting patient records is usually an indicator that an investigation is underway. An investigator may call and say there is a complaint and ask for records or to discuss the matter.

The OPMC investigation is a fact-gathering process. Investigators and clinicians, including physicians, review medical records and interview anyone who may have knowledge relevant to the situation. The goal of this activity is to gather and analyze all relevant information to determine if evidence suggests that there was misconduct.

OPMC investigations include strong confidentiality protections. For example, Public Health Law requires the OPMC to keep the name of the complainant confidential. The very existence of an investigation is also confidential until completed. These provisions exist for the protection of both the complainant and the physician being investigated.

The OPMC also ensures that the physician has due process throughout. The physician may be represented by an attorney and may submit information to the OPMC at any time during the investigation. State Public Health Law Section 230(10) requires that a physician be given the opportunity to be interviewed by OPMC staff to provide an explanation of the issues under investigation if the matter is going to be referred to the Board. This interview may be conducted in person or over the telephone, and the physician may have an attorney present. The physician may bring a stenographer to transcribe the interview, at his/her expense.

In many cases, even if the matter does not result in a referral to the Board, the physician is contacted to respond to the issues in the complaint. Cases are not referred to the Board when there is insufficient evidence to proceed or the issues are determined at that point to be outside of its jurisdiction. Physicians contacted in such cases are advised by letter that the matter is closed.

Part of the fact-gathering process involves the Board. Public Health Law Section 230(7) provides that a committee of the Board may direct a physician to submit to a medical or psychiatric examination when the committee has reason to believe the licensee may be impaired by alcohol, drugs, physical disability or mental disability. These evaluations provide valuable expert information about the possible presence of an impairment.

A critical component of the investigation process is the expert review. Public Health Law Section 230(10)(a)(ii) requires that medical experts be consulted when an investigation involves issues of clinical practice. Physicians who are board-certified in their specialty, and who are not employed by the OPMC, review the investigative information and identify whether the physician under review met minimum standards of practice or did not. The peer review aspect of the process is key to making fair and appropriate determinations.

When the investigation finds evidence that appears to indicate that misconduct has occurred, the evidence is presented to an investigation committee of the Board for review. The investigation committee is comprised of two physician Board members and one public member. If a majority of the committee concurs with the Director of the OPMC (Director) that sufficient evidence exists to support misconduct, and after consultation with the Executive Secretary to the Board, the Director directs counsel to prepare charges.

The committee may take actions other than concurring that a disciplinary hearing is warranted. The committee may recommend to the Commissioner of Health that a physician's practice be summarily suspended because he or she poses an imminent danger to the public health. If there is substantial evidence of professional misconduct of a minor or technical nature or of substandard medical practice which does not constitute professional misconduct, the Director, with the concurrence of the committee, may issue an administrative warning and/or provide for consultation with a panel of one or more experts, chosen by the Director. Administrative warnings and consultations are confidential.

Disciplinary Hearings

In some cases that are referred for charges, a disciplinary hearing is avoided through a consent agreement signed by the physician, the Director and the Board Chair. Such agreements put terms in place that adequately protect the public and address the misconduct identified in the agreement. Many cases, however, proceed to a disciplinary hearing. If the case proceeds to a hearing or the Commissioner of Health orders a summary suspension, another three-member panel, including two physicians and a public member, is drawn from the Board to hear the case. A hearing is much like a trial, with the Board panel serving as the jury. An administrative law judge is present to assist the panel on legal issues. The State's case is presented by a Department of Health attorney and physicians generally choose to be represented by counsel. At the hearing, evidence is presented and testimony may be given by witnesses for both sides.

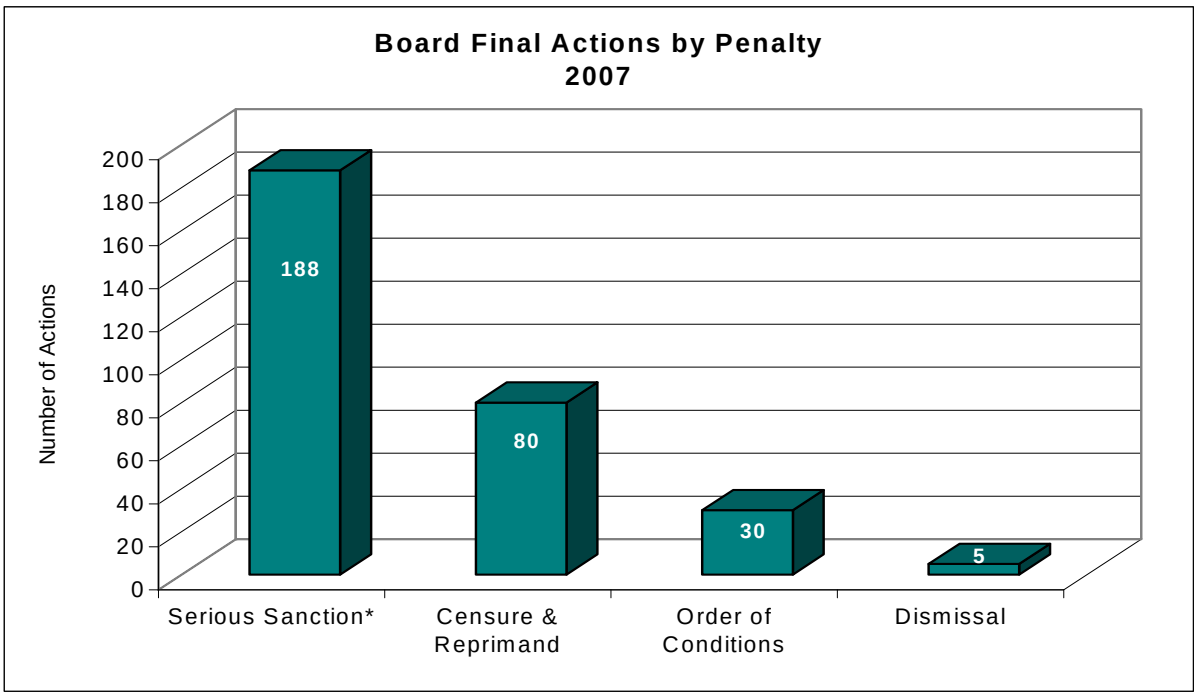
Public Health Law requires that hearings start within 60 days of the service of charges or, in cases of summary suspension, within 10 days of the service of charges. The last hearing day must be held within 120 days of the first hearing day. The hearing panel's decision must be issued within 60 days of the last hearing day. Changes in these time frames can be made by agreement of both sides.

A hearing panel first rules on whether misconduct exists or not, deciding whether to dismiss or sustain some or all of the charges against the physician. If the hearing committee sustains charges, it decides on an appropriate penalty. Penalties can range from a censure and reprimand to license revocation. The panel may also suspend or annul a physician's license, limit his or her practice, require supervision or monitoring of a practice, order retraining, levy a fine or require public service. Revocations, actual suspensions and license annulments are immediately made public and penalties go into effect at once.

Other penalties are not made public until the period for requesting an appeal has passed. If there is an appeal, disciplinary action is stayed (delayed) until there is a resolution.

In 2007, the Board issued 303 final actions, including serious sanctions (see Figure 3).

Figure 3



* Serious sanctions include revocations, surrenders and suspensions.
Source: The Office of Professional Medical Conduct

Appeals

Either side may appeal the decision of a hearing panel to the ARB. The ARB is a standing panel, comprised of three physician Board members and two public members. The panel hears all administrative appeals.

Notices of appeal to the ARB must be filed within 14 days of the service of a hearing committee decision. Both parties have 30 days from the service of the notice of appeal to file briefs and another seven days to file a response to the briefs. There are no appearances or testimony in the appeals process.

The ARB reviews whether or not the determination and penalty of the hearing committee are consistent with the hearing panel's findings and whether the penalty is appropriate. The ARB must issue a written determination within 45 days after the submission of briefs.

In 2007, the ARB issued 13 decisions. Of those, 12 decisions upheld the hearing committee determination, and in eight decisions, the ARB upheld the penalty imposed by the original hearing panel. In the five cases in which the penalty was modified, the ARB increased the penalty four times, and decreased the penalty in one decision (see Figure 4).

Figure 4

Administrative Review Board Statistics 2006 - 2007

	2006	2007
Administrative Review Board Decisions	20	13
Hearing Committee Determination Upheld	16	12
Hearing Committee Determination Not Upheld	4	1
Hearing Committee Penalty Upheld	9	8
Hearing Committee Penalty Increased	9	4
Hearing Committee Penalty Decreased	2	1

Source: The Office of Professional Medical Conduct

Physician Monitoring Program

Impaired Physicians

Public Health Law Section 230(13) allows a physician who is temporarily incapacitated and is not able to practice medicine and whose incapacity has not resulted in harm to a patient, to voluntarily surrender his or her license to the Board. The OPMC carries out this provision through a program to identify these impaired physicians, rapidly remove them from practice, refer them to rehabilitation and place them under constant monitoring upon their return to active practice.

When the OPMC receives a report that a physician may be impaired, it investigates the report to determine the facts. If the evidence indicates that there is a problem with alcohol, drugs, mental illness or physical disability, OPMC may seek a non-disciplinary temporary or permanent surrender of the physician's license. The Board may accept and hold such licenses during the period of incapacity.

When a surrender is accepted, the Board promptly notifies entities including the State Education Department and each hospital at which the physician has privileges. The physician whose license is surrendered notifies all patients of temporary withdrawal from the practice of medicine. The physician is not authorized to practice medicine, although the temporary surrender is not deemed to be an admission of permanent disability or misconduct. During 2007, the OPMC held **64** surrendered licenses.

A surrendered license may be restored if the physician can demonstrate to the Board that he/she is no longer incapacitated for the active practice of medicine. A Board committee (two physicians and one public member), convenes a restoration hearing to determine whether the physician has made an adequate showing as to his or her rehabilitation.

If the Board restores the license, the physician is placed under a minimum monitoring period of five years. Monitoring terms generally require random and unannounced drug and alcohol screens, a medical practice supervisor, a treatment monitor, abstinence from drugs and/or alcohol and self-help group attendance (Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Caduceus). As of December 31, 2007, the OPMC was monitoring **383** licensees who were in recovery from alcohol, drugs, mental illness or physical disability, pursuant to New York State Public Health Law Section 230(13).

Probation

The OPMC is also responsible for monitoring physicians placed on probation, pursuant to a determination of professional misconduct, under Public Health Law Section 230(18). The Board places a physician on probation when it determines that he/she can be rehabilitated or retrained in acceptable medical practice. It is the same underlying concept used in placing physicians impaired by drugs/alcohol under monitoring.

Public Health Law Section 230(18) authorizes the OPMC to perform appropriate monitoring activities, including but not limited to, reviewing a random sample of the licensee's office records, patient records and hospital charts, conducting onsite visits, assigning another physician to monitor the licensee's practice, auditing billing records, testing for the presence of alcohol or drugs and requiring that the licensee work in a supervised setting.

Additionally, each physician on probation meets with the OPMC monitoring investigator and the medical director to review the terms and conditions of his/her Board order and discuss patient care or other issues identified during probation.

The prime focus of probation, in addition to monitoring compliance, is education and remediation. Working with professional societies, hospitals and individual practitioners, the probation program allows for close scrutiny of the physician's practice, early identification of necessary adjustments to the probation terms and support for the physician's rehabilitation and training. During 2007, OPMC monitored **951** licensees.

Board Accomplishments

Committee for Physician Health and Board for Professional Medical Conduct

The OPMC is responsible for overseeing the contract with the Medical Society of the State of New York, Committee for Physician Health (CPH) – a non-disciplinary program to identify, refer to treatment and monitor impaired physicians. The Joint Committee of the Committee for Physician Health and the Board for Professional Medical Conduct (Joint Committee) was established to develop recommendations that will enhance the continued efforts of New York State's impaired physician programs to both protect the public and assist physicians in need.

In 2007, the Joint Committee discussed how to address the issue of disruptive physician behavior. This issue has been emerging across the nation as disruptive behavior by doctors may have an adverse impact on patient care. The Joint Committee is studying how to properly identify disruptive behaviors, what causes them and how to appropriately treat them to prevent recurrence. The group will also identify available assessment and treatment resources with specialized expertise in this area to help address this problem.

During the past year, the CPH staff conducted 60 outreach and education seminars with over 3,500 persons in attendance.

Hospital Reporting Requirements

Hospitals are statutorily required to report any information to the Board that reasonably appears to show that a licensee may be guilty of misconduct. Each year, approximately 20 percent of the hospital reports of misconduct involve allegations of possible impairment. In the 2007, OPMC received 120 reports from hospitals regarding physician misconduct, 17 of which were related to concerns of physician impairment. These figures are consistent with the OPMC's 2006 experience, when 114 reports were submitted including 16 related to impairment.

Office-based Surgery Legislation

Legislation to protect patients undergoing certain surgical procedures in physicians' offices was signed by the Governor on July 20, 2007. The legislation provides for appropriate patient safety standards for certain surgical procedures performed in a doctor's office. Prior to this legislation, surgeries performed in doctors' offices were not regulated in New York State. The legislation is based on recommendations made by the Committee on Quality Assurance in Office-based Surgery, established in 1997 by the New York State Public Health Council.

The new office-based surgery law:

- Requires that office-based surgery be performed by physicians in a setting that has obtained and maintained accreditation from an entity approved by the State Health Commissioner. This requirement becomes effective in 2009;

- Determines that operating in a non-accredited setting would constitute professional misconduct; and

- Requires physicians to report adverse office-based surgery events, including patient deaths and unplanned hospital admissions, within one business day to the Department of Health's Patient Safety Center, effective January 2008. The failure to do so constitutes professional misconduct.

The OPMC and the Board will investigate any referrals made related to these requirements to ensure patient safety in office-based surgery.

Program Highlights

Complaints and Investigations

- During 2003-2007, the average number of actions taken per year is 350, an eight percent increase over the average of 325 taken per year during 1993-1997.

- During 1998-2007, the number of complaints received has increased an average of four percent per year. In 2007, there was a 42 percent increase in complaints received (8,222) compared to the number of complaints received (5,782) in 1997.

- In 2007, the time for investigation of all cases averaged 223 days, a ten percent decrease in investigation time from the 1997 average of 248 days. For cases referred to counsel for charges, the investigation time in 2007 was 268 days, a 28 percent decrease from the 1997 average investigation time of 371 days.

New Medical Malpractice Initiatives

With a growing national interest in and concern about the potential of medical malpractice experience as a predictor of misconduct, the OPMC took several steps to improve its use of medical malpractice information.

State Insurance Law, Chapter 28, Article 3, Section 315, mandates the reporting of any claim filed for medical malpractice against a physician, physician assistant or specialist assistant, to be reported to the Commissioner of Health, as well as the Superintendent of Insurance. The data system developed to collect this information is the Medical Malpractice Data Collection System (MMDCS). The OPMC is reviewing data reporting processes to identify improvements that are necessary to make submitting data easy for mandated reporters. The OPMC worked with hospitals in 2007 to identify self-insured facilities and to ensure their compliance with reporting requirements.

In addition, the OPMC is reviewing its existing criteria for opening a complaint, based on medical malpractice information. For example, the OPMC previously employed a fixed dollar threshold for any payment agreed to as a result of the malpractice claim, whether determined by settlement or judgment; if a payment amount was above the threshold, a complaint was initiated. In 2007, this criterion was changed to establish a threshold that is specialty-specific, to recognize the variation in average payments across specialties.

The OPMC also reviews all medical malpractice cases involving a patient death. Last year, the OPMC began to review the relevance of employing a frequency standard for medical malpractice payouts. The program began to study the value of opening an investigation based on a frequency standard of a certain number of payouts within a specific period of time. It will take some time to identify any conclusions from this effort, but its results have the potential to influence future legislation, as well as OPMC investigation policy and procedures.

Improving Case Management

The OPMC established an automated case management system to assist investigators and managers to monitor investigative progress and facilitate timely, high-quality investigations. The system, known as Trakker, was fully deployed statewide in December 2007. Trakker is best described as a case organizer. The deployment allows Trakker users to track every interchange of a case statewide. Trakker is analogous to a filing cabinet containing all aspects of the work that has been performed on any case and aggregating that data to provide a coherent presentation. Trakker is an investigative tool that permits investigators to look at closed cases as well as open ones to easily cross-reference data about physicians or to quickly call up information on past investigations.

Criminal Reporting Responsibility

Effective September 2003, the OPMC is required to notify the appropriate district attorney when, based upon a reasonable belief, a physician has committed a criminal offense. Since its inception, the OPMC has made a total of 50 referrals: 11 in 2007, 14 in 2006; and 25 for the period September 2003 through the end of 2005.

Internet Access to Physician Information

Information regarding the OPMC and Board can be accessed through the Department of Health's Web site, www.nyhealth.gov, then clicking on "Physician Discipline." All disciplinary actions taken since 1990 are posted on the OPMC's site, as well as information on how to file a complaint, brochures regarding medical misconduct, frequently asked questions and relevant statutes.

The OPMC received nearly 1,300 e-mail requests for information and assistance in 2007, a 40 percent increase since 2005, demonstrating that consumers are becoming increasingly aware of the information and assistance available from the OPMC.

National Ranking and Awards

Federation of State Medical Boards

The Federation of State Medical Boards (Federation) is a national not-for-profit organization representing 70 medical boards within the United States and its territories. As the representative body and forum for physician licensing and disciplinary boards, the Federation co-sponsors the United States Medical Licensing Examination (USMLE) with the National Board of Medical Examiners (USMLE).

National Ranking

The Federation released its annual report on medical board performance. In 2007, the Board for Professional Medical Conduct took 279 serious disciplinary actions, resulting in restriction or loss of license and was second only to California which took 320 actions.

Following release of the Federation's annual report, Public Citizen, a national consumer advocacy group, issued its annual ranking of state medical board performance. The rankings are achieved using physician population data from the American Medical Association and disciplinary data from the Federation. For the period 2005-2007, New York ranked 19th in the nation in the number of serious disciplinary actions taken, with 3.73 actions per 1,000 physicians. Alaska ranked number one with 8.33 actions per 1,000 physicians and South Carolina was ranked lowest with 1.18 actions per 1,000 physicians. New York ranked 20th in 2002 and 49th in 1991.

Awards

The 2007 John H. Clark, M.D. Leadership Award, established in 1986 in memory of the Federation's 61st president, was awarded to Ansel R. Marks, M.D., J.D., Executive Secretary of the Board. This award is given annually and recognizes an individual who has demonstrated outstanding leadership, a commitment to advancing the public good, dedication to the field of medicine, licensure and discipline at the state and national levels.

In 2006, an article describing New York's administrative warning (AW) process was published in the Federation's *Journal of Medical Licensure and Discipline*. AWs are powerful tools used by the Board and the OPMC to advise and educate physicians about substandard medical practice of a minor or technical nature that does not rise to the level of misconduct under the law. These warnings are most often delivered in person by the Executive Secretary of the Board. Since the year 2000, 963 licensees received AWs. The Board has recognized the value of AWs as vehicles for informing physicians and physician assistants of practice problems before the issues escalate to the level of misconduct. Publication of the article in the Federation's *Journal of Medical Licensure and Discipline* provided New York with an opportunity to showcase this innovative program as a model.

Administrators in Medicine (AIM)

Administrators in Medicine (AIM) is a non-profit organization composed of state government physician licensing programs in the United States. The AIM supports administrators for medical licensing and regulatory authorities by promoting an understanding of the regulatory role and helping administrators carry out their responsibilities. AIM's mission includes providing centralized information on all state board actions, making it easier for administrators to access information to more efficiently and effectively carry out their administrative responsibilities and the mission of their respective Boards.

The OPMC's One-stop Physician Search (OOPS)

In 2007, the OPMC received an Honorable Mention Award for its entry in the 2007 AIM Best of Boards Award Program for "Outstanding Best Practices and Innovation in Recognition of OOPs: OPMC's One-Stop Physician Search Software Tool."

The OPMC requires its investigators to access information from numerous databases to prioritize complaints, conduct initial research, develop leads and execute sound investigative strategies. The OOPS is a Web application developed by the OPMC that allows users to access a wide variety of data sources through a single search.

With one login, the software returns all available licensing and registration information from the State Education Department, medical malpractice data from the Medical Malpractice Data Collection System and information from the OPMC's own records. The information is secured through the regular OPMC network protocols. The OOPS improves efficiency in obtaining vital information, helping to improve the timeliness of investigations.

Office of Professional Medical Conduct

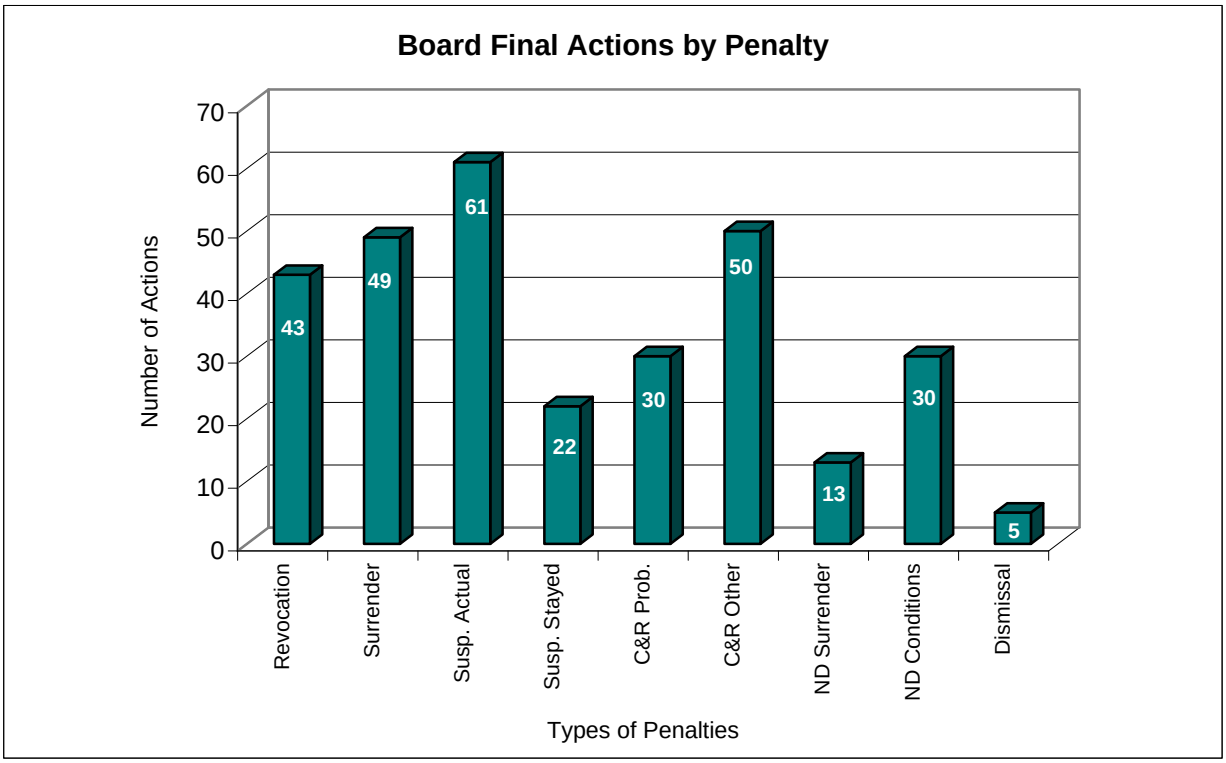
Summary Statistics

Year	2003	2004	2005	2006	2007
Complaints Received	6275	6925	7358	8001	8222
Investigations Completed	6882	6711	7032	7372	8024
Licensees Referred for Charges	354	337	326	383	311
Administrative Warnings/Consultations	166	123	110	101	99
Summary Suspensions*	37	19	28	24	16

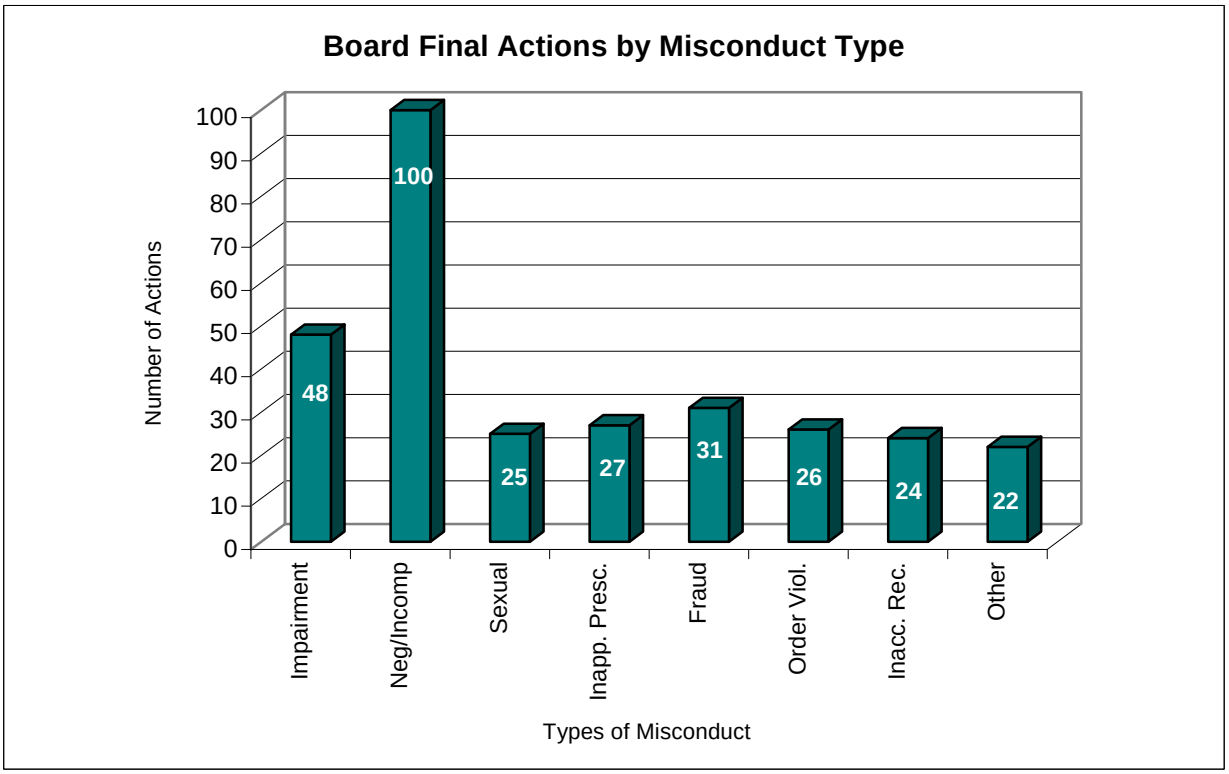
Actions

Surrender	60	84	67	60	49
Revocation	34	15	30	32	43
Suspension	117	96	85	90	83
Censure and Reprimand/Probation	49	55	69	42	30
Censure and Reprimand/Other	62	45	46	69	50
Dismiss	9	5	6	4	5
Surrenders under 230(13)	13	23	22	15	13
Monitoring Agreements	27	44	37	35	30
TOTAL ACTIONS	**371**	**367**	**362**	**347**	**303**

* In 1996, Public Health Law 230 was amended to permit a summary suspension when a licensee has pleaded or been found guilty or convicted of committing an act constituting a felony under New York State Law or federal law, or the law of another jurisdiction which, if committed within this State, would have constituted a felony under New York State law, or when the duly authorized professional agency of another jurisdiction has made a finding substantially equivalent to a finding that the practice of medicine by the licensee in that jurisdiction constitutes an imminent danger to the health of its people.



Source: The Office of Professional Medical Conduct



Source: The Office of Professional Medical Conduct

State of New York

Department of Health
Richard F. Daines, M.D., Commissioner