



New York State Department of Health

Board for Professional Medical Conduct

2014 Report

Office of Professional Medical Conduct
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Board for Professional Medical Conduct

2014 REPORT

Executive Summary

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 (DOH/Department) Office of Professional Medical Conduct (Office/OPMC), administers the State's physician discipline program. Its mission is patient safety -- to protect the public from medical negligence, incompetence and other kinds of professional misconduct.

The Board, through the OPMC, investigates complaints made against the nearly 110,000 physicians, physician assistants and specialist assistants and prosecutes those charged with misconduct. It also monitors licensees who have been impaired or who have been placed on probation by the Board.

The Program achieved the following during 2014:

- The Board imposed 325 final actions in 2014. Of those, 78% (253) were serious sanctions, including the loss, suspension, or restriction of a physician's medical license.
- The Office received 7,945 complaints and closed 8,271 complaints in 2014. These closures include various administrative reviews, as well as full field investigations assigned to the Regional Offices and Investigative Units.
- 2,474 full field investigations were closed in 2014, similar to last year's experience.
- The average time to complete a full field investigation is 268 days.
- The OPMC monitored 1,389 physicians during 2014, nearly the same as in 2013.

Protecting Patient Safety by Addressing Medical Conduct

Board for Professional Medical Conduct

The State Board for Professional Medical Conduct, with the Department of Health's Office of Professional Medical Conduct, administers the State's physician discipline program. Its mission is to protect the public from medical negligence, incompetence and other kinds of professional misconduct by the more than 110,000 physicians.¹ The Board is a vital patient safety protection for those who access New York's health care system.

Public Health Law (PHL) Section 230(14) requires a report to the Legislature, the Governor and other executive offices, the medical profession, medical professional societies, consumer agencies and other interested persons. This report discusses the Board's 2014 experience.

The Board consists of 84 physician and 30 non-physician lay members. Lay members include members of the general public, to ensure that the patient perspective is represented on the Board. Physician members are appointed by the Commissioner of Health with recommendations for membership received largely from medical and professional societies. The Commissioner, 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.

Through its activity, the Board ensures the participation of both the medical community and the public in this important patient safety endeavor.

Office of Professional Medical Conduct

The OPMC's mission is to carry out its statutory mandate and the objectives of the Board to deter medical misconduct and promote and preserve appropriate standards of medical practice. Through its central office in Albany, New York and six field offices (Buffalo, Rochester, Syracuse, New York City, New Rochelle and Central Islip), 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 by the Board;

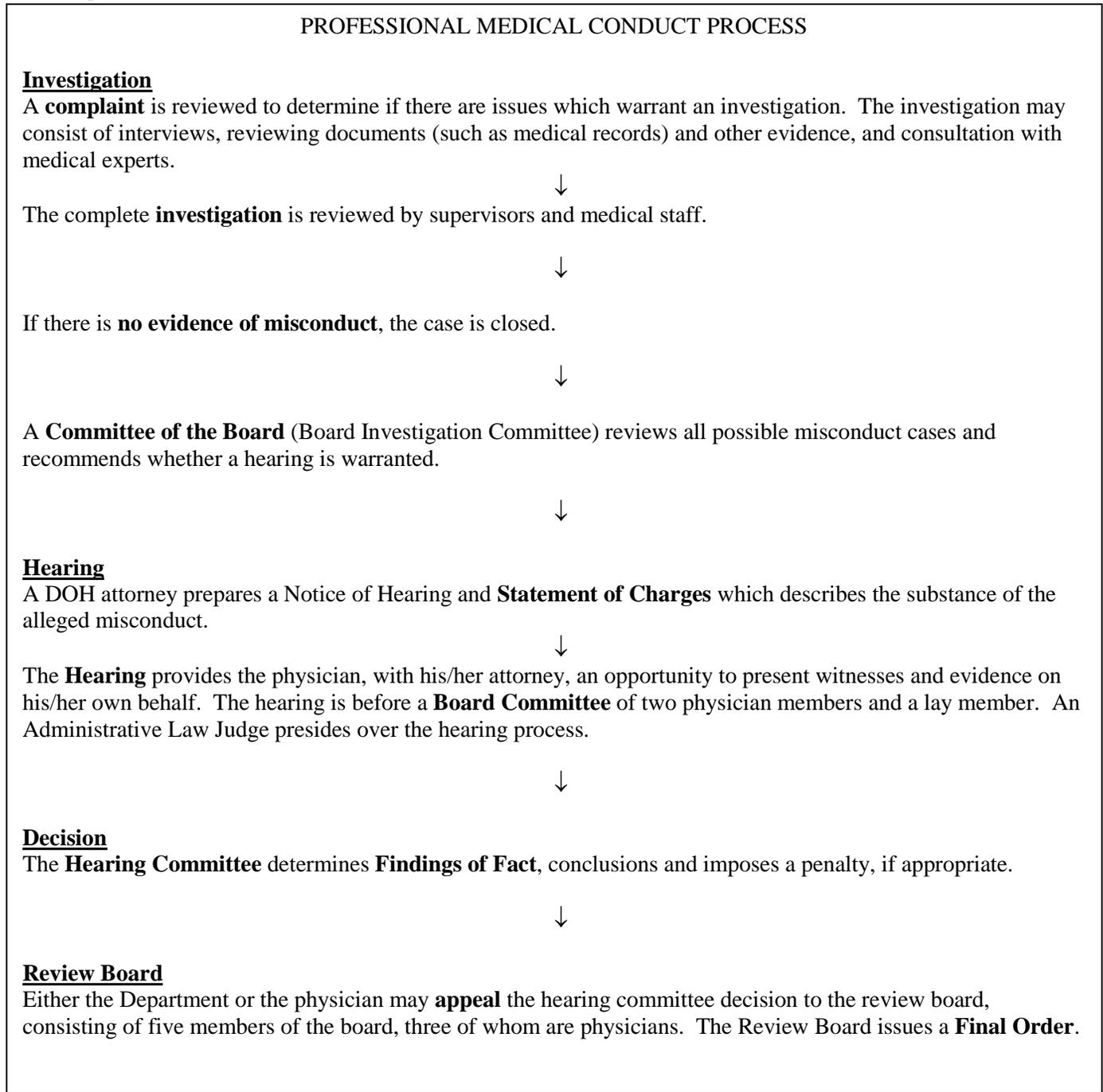
¹ In this report, "physician" and "licensee" refer to licensed medical doctors [MDs], doctors of osteopathy [DOs], physicians practicing under a limited permit, medical residents, physician assistants and specialist assistants.

- 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, to assist physicians return to safe practice;
- Collects and maintains reports of medical malpractice claims filed in New York State and their dispositions. The OPMC reviews medical malpractice reports to identify potential misconduct that warrants further review and, as appropriate, investigation;
- Oversees the administration of the New York State Physician Profile, a single point of information for the education, training, practice, legal actions and professional activities of every physician licensed and registered to practice in New York State; and
- Supports all Board activities, including appointments, training, recruitment of medical experts and coordination of the procedures for the approximately 70 committees of the Board that were convened in 2014; and
- Educates the physician community and others on misconduct definitions, trends in investigative findings, and best practices to avoid misconduct. In 2014, for the first time, the OPMC provided educational programs to medical students and physician assistant students, so that students are aware of what misconduct is and how they can avoid misconduct once they begin practice.

New York's Medical Conduct Process

Public Health Law (PHL) and Education Law (EL) govern the State's physician discipline program. The process is defined in PHL Section 230, while the definitions of misconduct are found in Sections 6530 and 6531 of the Education Law. The process is described in Figure 1.

Figure 1. The Professional Medical Conduct Process



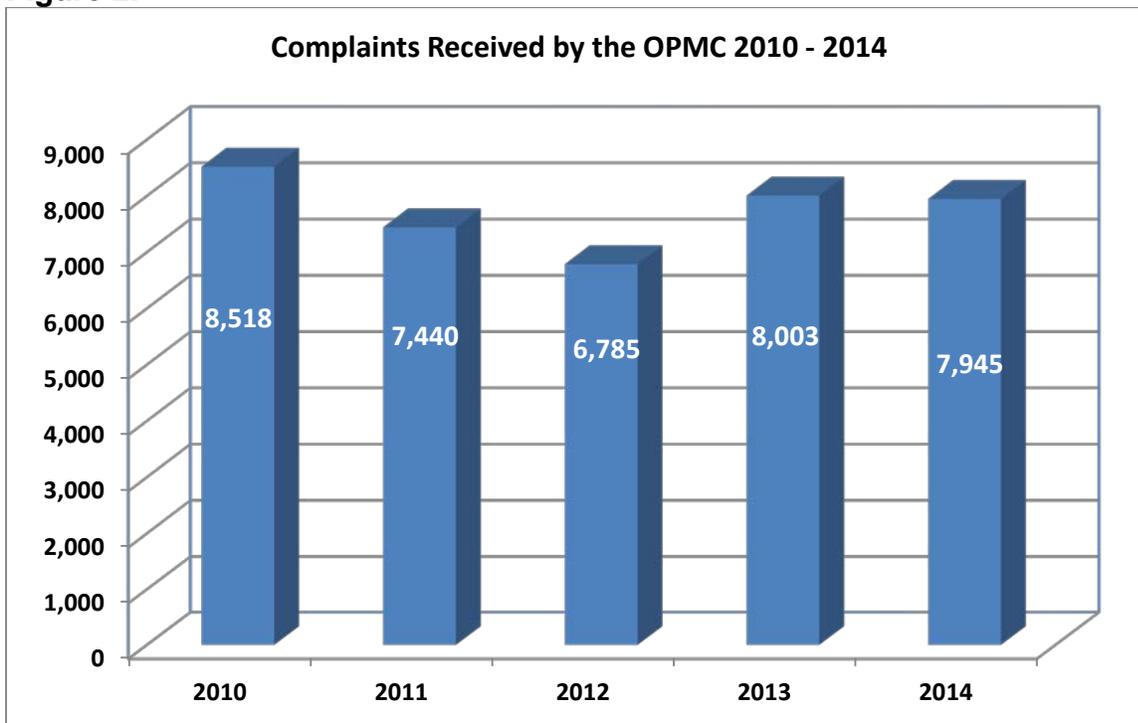
Complaints

The OPMC is required by PHL Section 230(10) to review every complaint it receives. Complaints come from many sources including the public, the health care community and others. Complaints may also be opened as a result of a report in the media a referral from another government agency, or OPMC's own review of information, such as medical malpractice data and compliance with statutory requirements related to the New York State Physician Profile.

In 2014 the OPMC received 7,945 complaints, the third largest in the last five years and nearly the same as in 2013. (see figure 2).

Every complaint is reviewed to determine whether the subject of the complaint is a physician (thereby falling under the OPMC's jurisdiction), and whether the allegation, if found true, would be medical misconduct. In 2014, 47 percent of all complaints moved forward after this initial review for further investigation. The OPMC makes referrals to other agencies as appropriate.

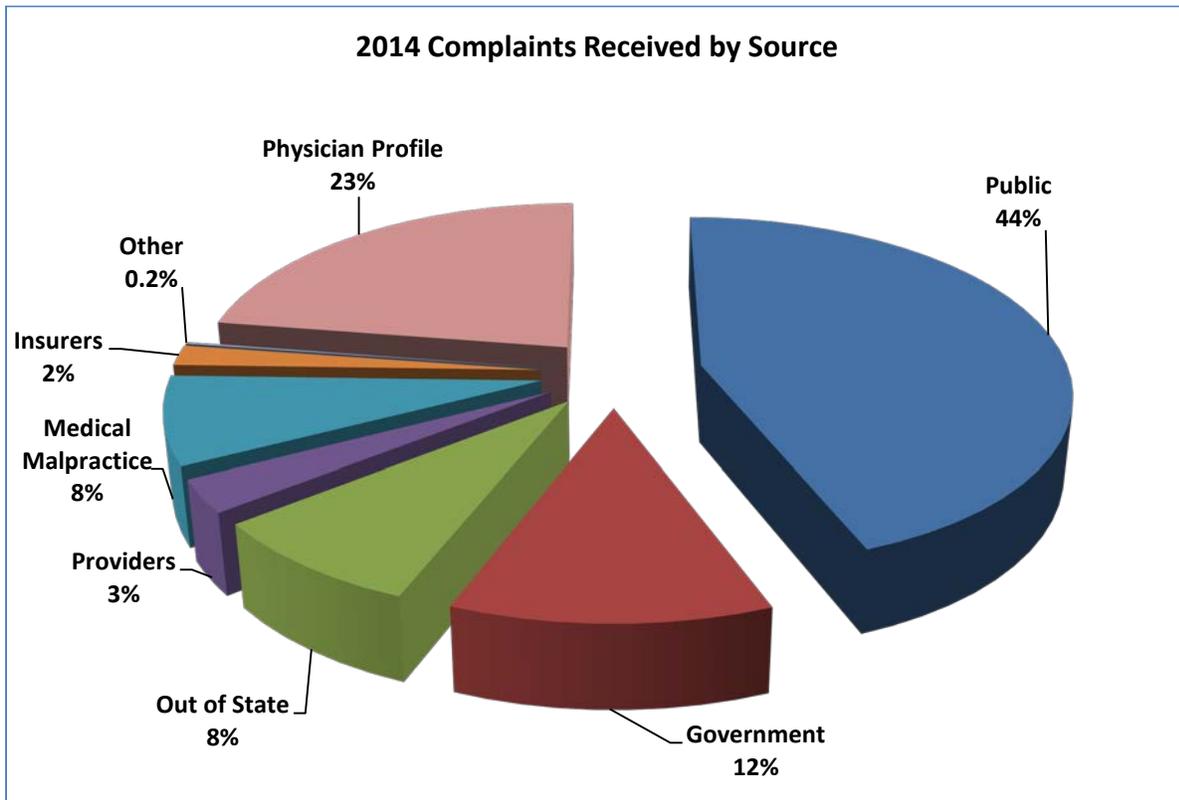
Figure 2.



Source: The Office of Professional Medical Conduct

About 44 percent of the complaints received in 2014 came from the public (see Figure 3). About 3% of complaints come from providers.

Figure 3.



Source: The Office of Professional Medical Conduct

Investigations

OPMC investigators and clinicians, including Board Certified physicians, gather and analyze all relevant information from documents such as medical records and interviews to determine whether the evidence suggests that misconduct occurred. The investigative process ensures a thorough review and supports an informed determination by the Office and the Board as to whether the allegation is substantiated and, if so, constitutes 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 under review.

The physician is ensured due process throughout. The physician has a right to submit relevant information to the OPMC at any time during the investigation. Under the law, the OPMC must offer the physician an opportunity to be interviewed to comment on the issues under investigation if the OPMC intends to refer the matter to the Board. The physician may have an attorney present and may bring a stenographer to transcribe the interview, at his/her expense.

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 its jurisdiction.

The Board can collect valuable information through its PHL § 230(7) authority; through a committee, the Board may:

- direct a physician to submit to a medical or psychiatric examination when a Board committee empaneled under this section of the law has reason to believe the licensee may be impaired by alcohol, drugs, physical disability or mental disability;
- direct the OPMC to obtain medical records or other protected health information pertaining to the licensee's physical or mental condition when the Board has reason to believe that the licensee may be impaired by alcohol, drugs, physical disability or mental disability or when the licensee's medical condition may be relevant to an inquiry into a report of a communicable disease; and
- direct a physician to submit to a clinical competency examination.

With these tools, the Board can determine the presence and magnitude of any issues facing the physician, and evaluate if these issues might present a risk to patients.

In investigations related to clinical care, information gathered by the OPMC is reviewed by medical experts who are board certified in their specialty, currently in practice and who are not employed by the OPMC. The expert identifies 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 evidence indicates that misconduct has occurred, it is presented to an investigation committee of the Board for review. If a majority of the committee, comprised of two physician members and one public member, 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. In 2014, the OPMC referred 221 physicians for charges.

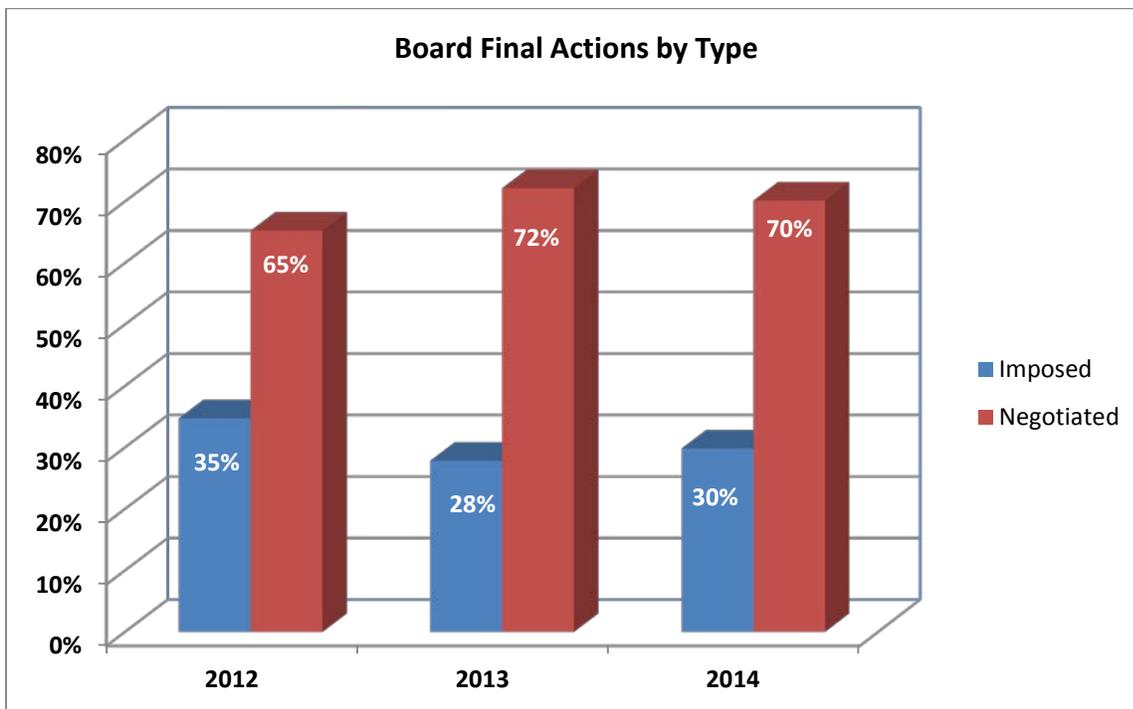
The Board is required to make charges public no earlier than five business days after charges are served upon a physician after an investigation committee has unanimously concurred with the Director's determination that a hearing is warranted. A statement advising that the charges or determinations are subject to challenge by the physician will accompany the charges.

The committee may take actions other than concurring that a disciplinary hearing is warranted. These range from a recommendation 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, to a confidential administrative warning 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.

Disciplinary Hearings

For some investigations that result in a referral for charges, a disciplinary hearing is avoided through a signed consent agreement between the physician and the Board. These agreements include terms that adequately protect the public and address the physician's misconduct without incurring the time and costs of a hearing. In 2014, approximately 70% of Board actions resulted from negotiated agreements. (See Figure 4).

Figure 4.



Source: The Office of Professional Medical Conduct

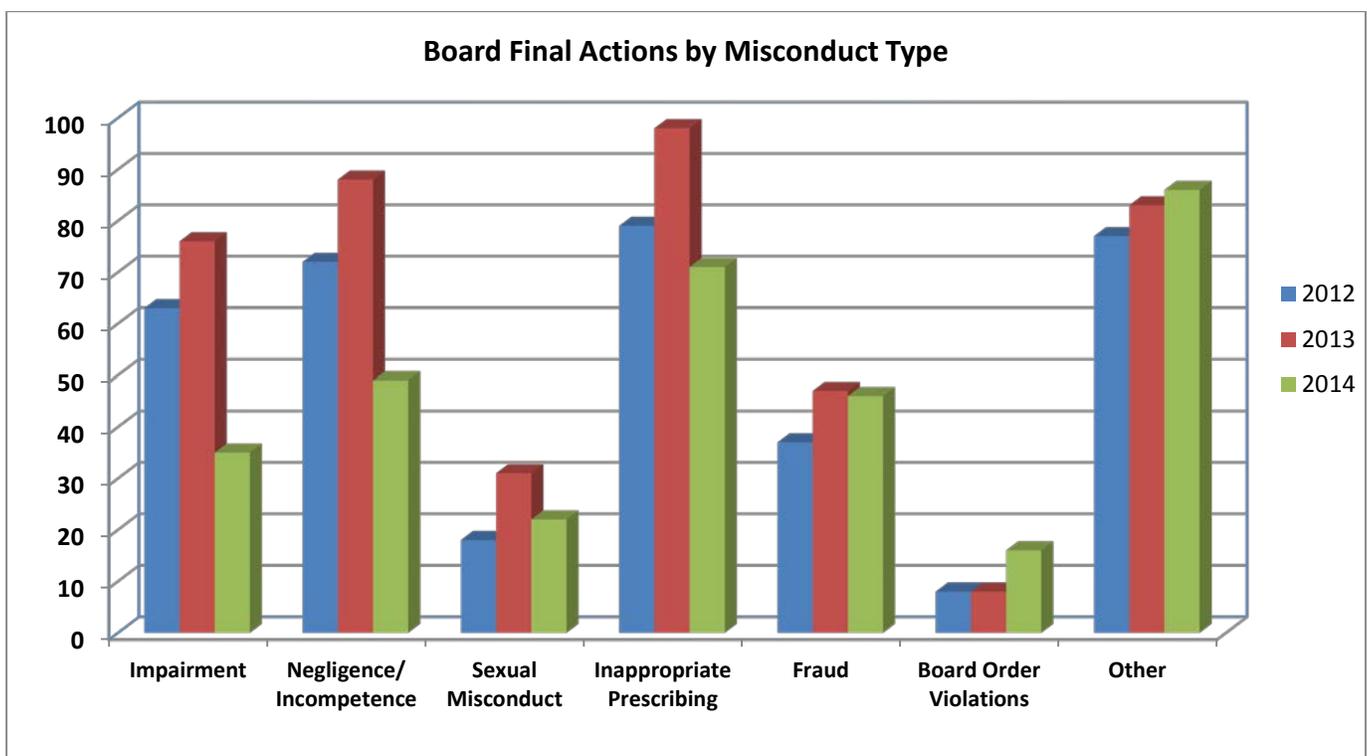
If the investigation proceeds to a hearing or the Commissioner of Health orders a summary suspension, another three-member Board panel (two physicians and one lay member), known as a Hearing Committee, hears the case. An administrative law judge assists the committee on legal issues, and evidence and testimony may be presented by attorneys for the Department and the physician.

The Board Hearing Committee rules on whether misconduct exists or not by sustaining or not sustaining specific charges. If the committee sustains charges, it decides on an appropriate penalty. Penalties can range from a censure and reprimand to license revocation, including but not limited to, suspension of a physician's license, limitation of his or her practice, requiring supervision or monitoring of a practice, or a fine. Hearing committee determinations are immediately made public.

Revocations, actual suspensions and license annulments go into effect at once and are not stayed (postponed) if there is an administrative appeal. Other penalties are stayed until the period for requesting an appeal has passed, and if there is an appeal, disciplinary action is stayed until there is a resolution.

Most of the final Board actions (69%) are related to five areas of misconduct: negligence/incompetence, sexual misconduct, inappropriate prescribing, impairment, and fraud (See Figure 5).

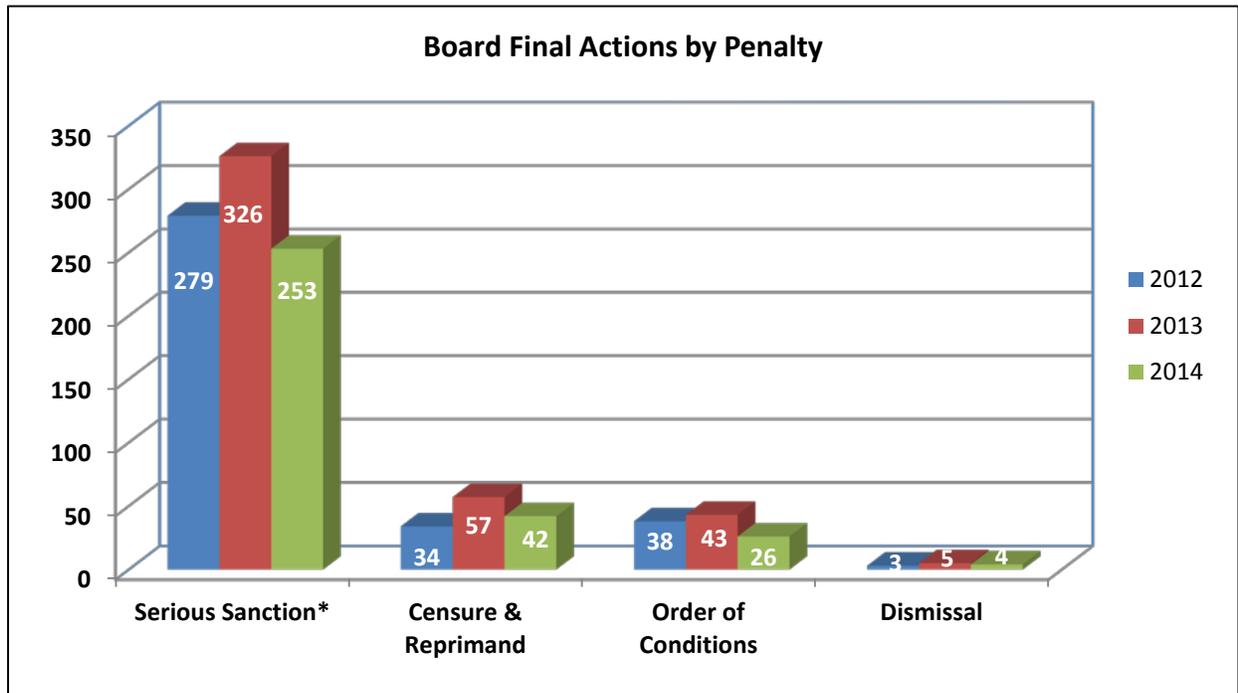
Figure 5.



Source: The Office of Professional Medical Conduct

In 2014, the Board issued 325 final actions; 253 of these final actions (78%) were serious sanctions including the revocation, surrender, or suspension of a physician’s medical license, or a limitation or restriction placed on the doctor’s license (see Figure 6). This demonstrates the Board’s response to misconduct that presents serious risk to patient safety.

Figure 6.



* Serious sanctions include revocations, surrenders, suspensions and restrictions or limitations of medical licenses.

Source: The Office of Professional Medical Conduct

The Board has jurisdiction over all physicians licensed to practice in New York. Many physicians who are trained in New York move to live and practice in other states but retain their New York license. When a medical board in the state in which they practice takes an action against the physician, New York and any other state in which the physician is licensed are notified through the Federation of State Medical Boards (FSMB).

The Board may impose a penalty against the physician to ensure that patients in New York State are protected. For example, if the nature of the misconduct is such that the physician presents a serious safety risk, the Board may revoke the doctor's license to practice in New York. The Board might otherwise impose a penalty that includes appropriate monitoring provisions to ensure that, if the physician does commence practice in New York, the risk to the health and safety of patients is minimized. This patient safety goal is the foundation for all Board actions, whether imposed against physicians practicing in New York or elsewhere.

Appeals

Either side may appeal the decision of a hearing committee to the Administrative Review Board (ARB), comprised of three physician members and two lay members of the Board. The ARB hears all administrative appeals.

There are no appearances or testimony in the appeals process. The ARB reviews whether the determination and penalty of the hearing committee are consistent with the hearing committee’s findings and whether the penalty is appropriate. The ARB must issue a written determination within 45 days after the submission of briefs.

From 2012-14, the ARB issued 33 decisions. (See Figure 7) The ARB upheld the hearing committee determination 94 percent of the time, and upheld the penalty imposed approximately half of the time.

Figure 7

Administrative Review Board Statistics 2012 - 2014			
	2012	2013	2014
Administrative Review Board Decisions	12	12	9
Hearing Committee Determination Upheld	11	11	9
Hearing Committee Determination Not Upheld	1	1	0
Hearing Committee Penalty Upheld	7	5	6
Hearing Committee Penalty Increased	2	4	1
Hearing Committee Penalty Decreased	3	3	2

Source: The Office of Professional Medical Conduct

Physician Monitoring Program

Impaired Physicians

Ensuring that physicians who may be impaired by an illness can safely practice medicine is a priority patient safety goal of the Board. PHL§ 230(13) allows a physician who is temporarily incapacitated, 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 uses this tool to identify these impaired physicians, rapidly remove them from practice, refer them to rehabilitation and place them under monitoring upon their return to active practice to ensure that they practice safely.

When a surrender is accepted, the Board promptly notifies entities, including the State Education Department (SED) 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. At the end of 2014, the OPMC was holding 44 temporarily surrendered licenses.

A surrendered license may be restored when 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 lay member) determines whether the physician has made an adequate showing as to his or her rehabilitation. Of the two physicians who petitioned the Board for license restoration in 2014, one was granted restoration and the other was withdrawn.

If the Board restores the license, the physician is placed under a minimum monitoring period of five years. Monitoring terms generally require abstinence from drugs and/or alcohol with random and unannounced drug screens, a medical practice supervisor, a treatment monitor and self-help group attendance such as Alcoholics Anonymous. As of December 31, 2014, the OPMC was monitoring 481 licensees who were in recovery from alcohol, drugs, mental illness or physical disability.

Probation

The OPMC also monitors physicians placed on probation, pursuant to a determination of professional misconduct, under PHL 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.

The OPMC monitors physicians using tools such as reviewing a random sample of the licensee's office and patient records, conducting onsite visits, assigning another physician to monitor the licensee's practice, auditing billing records, and testing for the presence of alcohol or drugs.

Probation ensures compliance with the Board order, and supports the physician's education and remediation. Working with professional societies, hospitals and individual practitioners, the program allows for close scrutiny of the physician's practice, early identification of necessary adjustments to and support for the physician's rehabilitation and training. During 2014, the OPMC monitored 1,389 licensees.

Sometimes, a physician does not comply with the terms of his/her Board order. Violation of the terms of a Board order is a serious matter; it may reflect a disregard for or a lack of understanding of the purpose and importance of the requirement. The Office and the Board must respond to these violations, to ensure the physician's compliance with these important patient safety protections.

In 2014, six physicians were referred to a disciplinary hearing for failure to comply with probation terms. The Board imposed actions against 16 physicians Board actions resulting from failure to comply with previous Board orders; 13 of the actions resulted in the loss of the physician's license to practice medicine.

Committee for Physician Health and the Board for Professional Medical Conduct

The OPMC oversees 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 CPH and the Board, through a Joint Committee, monitor the program's activities and develop recommendations to enhance the impaired physician program's patient protection and physician support effectiveness.

At the end of 2014, a total of 405 physicians were enrolled in the CPH, with 86 new enrollees during the year. Of the new enrollees, 33% were self-referrals, and 44% of them were referred by their facilities (hospitals, nursing homes, clinics, etc.). This further demonstrates the effectiveness of the outreach and education provided by both the CPH and the OPMC. Both organizations conduct presentations to hospitals, medical societies, specialty societies, and other groups, sometimes jointly. The CPH and the OPMC work together to ensure that their message is consistent and emphasizes the risk that impairment presents to patients, and the importance of an impaired or potentially impaired physician seeking help. In 2014, approximately 14% of the CPH participants relapsed, and must be either re-enrolled in CPH programs, or are referred to the OPMC. CPH and OPMC continue to work collaboratively to protect patient safety and ensure access to effective physician support services.

Hospital Reporting to the OPMC

Hospitals are statutorily required to report any information to the Board that reasonably appears to show that a licensee may be guilty of misconduct. In 2014, the OPMC received 70 reports from hospitals regarding physician misconduct. Of these, 16% pertained to concerns of physician impairment.

Medical Malpractice Information

With a growing national interest in medical malpractice experience as a potential predictor of misconduct, the OPMC continually refines its use of malpractice information to identify and investigate potential medical misconduct.

State Insurance Law 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 and the Superintendent of Insurance.

PHL §230 directs the OPMC to continuously review medical malpractice information for the purpose of identifying potential misconduct. The OPMC currently uses the following criteria for determining whether an investigation should commence:

- six or more payouts over the past five years
- cancellation or non-renewal of the physician's malpractice policy by the insurer due to a concern about quality of care
- addition of a surcharge of 75% or more to a physician's policy

- a single payout amount higher than a specialty- and geography-specific 75th percentile dollar amount

Of the 105 investigations completed in 2014 that were based on medical malpractice criteria, about 1 percent resulted in a Board action or administrative warning.

The OPMC and the Department of Financial Services (DFS) continually work together with New York State medical malpractice insurers, hospitals and other mandated reporters to ensure complete and accurate reporting. The OPMC will continue to monitor malpractice experience to maximize its use as a predictor of possible misconduct.

Ensuring Safety in Office-based Surgery Settings

PHL §230-d requires licensees to report adverse events following OBS to the DOH's Patient Safety Center (PSC). Adverse events that must be reported include: 1) patient death within 30 days; 2) unplanned transfer to the hospital; 3) unscheduled hospital admission within 72 hours of the OBS for longer than 24 hours; or, 4) any other serious or life-threatening event. Failure to report an OBS adverse event within one business day of when the licensee became aware of the adverse event may constitute professional misconduct. Additional provisions of the law, effective July 14, 2009, require physicians to perform OBS only in accredited practice settings.

After reviewing an Adverse Event Report, if the PSC believes further review and investigation is warranted, it may refer the report to the OPMC for an investigation. At that point, the OPMC will commence an investigation which may include, but not be limited to, the following: medical record review by a board certified physician, interviews of various participants, and a site visit of the office setting.

Internet Access to Physician Information

Information regarding the OPMC and the Board can be accessed through the DOH Web site, www.nyhealth.gov, by clicking on "Physician / Physician Assistant – Board Actions." All disciplinary actions taken since 1990 are posted on the OPMC site, as well as information on how to file a complaint, brochures regarding medical misconduct, frequently asked questions and relevant statutes.

Expanding Outreach

The OPMC Director, Deputy Director and Chair of the Board frequently meet with county medical societies, state specialty societies, and hospitals to educate physicians about the medical conduct process, outcomes of the Board's work, and how to prevent misconduct. These meetings also provide an opportunity to invite physicians to get involved in the process through the medical expert program. In 2014, for the first time, the OPMC presented educational programs to Physician Assistant (PA) students on professional misconduct issues, to assist them in engaging in appropriate patient care and avoiding misconduct once they begin practice.

Prescribing of Controlled Substances

Together with the Department's Bureau of Narcotic Enforcement (BNE), the Board and the OPMC have battled the public health crisis of opioid abuse for several years. The BNE and OPMC partner to identify potential inappropriate prescribing, investigate and enforce appropriate prescribing standards, and educate prescribers and the public on ways to address this epidemic.

All OPMC physician education presentations include a discussion of opioid prescribing, to help physicians understand current standards and how to protect their patients from potential abuse while effectively treating their conditions.

In 2014, the OPMC initiated 125 investigations related to potential inappropriate controlled substance prescribing. The Board issued 71 orders against physicians found to have committed misconduct related to inappropriate/excessive prescribing. The Board and the OPMC will continue to aggressively respond to this issue.

Future Initiatives

OPMC has implemented several initiatives to improve its effectiveness, including policy and data efforts. Some are designed to enhance its use of technology and data to improve decision-making and efficiencies. These initiatives include:

- OPMC continues to explore methods of increasing the use of data in order to proactively identify physicians who may warrant OPMC review before an adverse event occurs.
- The Executive Secretary of the Board participates on the DOH Telehealth workgroup to assist in developing best-practices with regard to telemedicine.
- The OPMC investigative case management data system is being redesigned to improve functionality and utility for analysis, investigation, processing, resolution, and monitoring of complaints.
- The Medical Malpractice Data Collection System (MMDCS) is being updated to make it easier for mandated reporters to submit required data to the system and to retrieve information for their analyses, and to enhance the OPMC's ability to analyze the data for research and investigative purposes.

Summary

The Board and the Office continue to effectively investigate allegations of medical misconduct and take appropriate action when evidence demonstrates that misconduct occurs. These efforts will continue to ensure that medical care is delivered consistent with today's standards.

Office of Professional Medical Conduct

Summary Statistics

Year	2012	2013	2014
Complaints Received	6785	8003	7945
Complaints Closed	6894	6790	8721
Licensees Referred for Charges	284	291	221
Administrative Warnings/Consultations	73	72	68

Final Actions

	2012	2013	2014
Revocation	46	52	35
Surrender	62	69	71
Summary Suspension	44	33	29
Suspension - Actual / Stayed	40	67	61
Restriction/Limitation	75	85	48
Censure and Reprimand/Probation	7	7	12
Censure and Reprimand/Other	23	47	27
Fine Only / No Penalty	4	3	3
Dismissal	3	5	4
Surrenders under 230(13)	12	20	9
Monitoring Agreements	38	43	26
TOTAL ACTIONS	354	431	325

Source: The Office of Professional Medical Conduct

- * PHL§ 230(12) permits 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, or
 - there is information about the possible transmission of a communicable disease or evidence of a condition or activity constituting an imminent danger to the public.



State of New York

**Department of Health
Howard A. Zucker, M.D., J.D., Commissioner**