FOCUS: HOSPITAL AND HEALTH LAW

Physician Discipline in New York State

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The professional discipline of physicians and physician assistants follows a different path than the other professions regulated by the New York State Education Department. In 1991, the Board for Professional Medical Conduct ("the Board") and its Office of Professional Medical Conduct in the NYS Department of Health assumed responsibility. The process is contained in NY Public Health Law § 230. It should be noted that this is specific to physicians and physician assistants. Other health professionals come under the jurisdiction of the Office for Professional Discipline in the Department of Education. Other licensed professionals are subject to oversight by the Education Department, Secretary of State or the court system.

What is Professional Misconduct?

The Education Law[1] sets out more than forty actions which form the basis for allegations of misconduct. These include a multitude of professional sins which are common to all professions, and some unique to medicine, such as ordering unnecessary tests; fee splitting with non-physicians; HIPAA violations; failure to wear identification in a hospital; failure of an ophthalmologist to provide copies of a prescription for glasses; not disclosing the identification of participants in a procedure while the patient is under anesthesia; and abandoning patients. The statute also defines "practicing negligently on more than one occasion" as professional misconduct while gross negligence on one occasion is misconduct. Failure to comply with the Board is itself professional misconduct.

The 2021 Annual Report of the Board (the most recent available on their website)[2] notes that five allegations were responsible for 74% of the actions taken by the Board: negligent/incompetent practice; sexual misconduct; inappropriate prescription of controlled substance; being impaired due to drugs or alcohol; and fraud. Impairment is a major contributor to Office of Professional Medical Conduct ("OPMC") issues and the Board contracts with the Medical Society to operate Committee for Physician Health ("CPH") which identifies, refers for treatment, and monitors impaired physicians to get them safely back to practice.

The Process

According to the Board's 2021 report, 50% of complaints are received from the public. Investigations also arise from the OPMC's own research, through the National Practitioner Data Bank[3] and reporting of malpractice settlements by professional liability insurance companies or self-insured institutions.[4] Complaints may also be generated through information from the media or referrals to OPMC from other government agencies. Actions taken against a practitioner's privileges by a hospital also generate a report. NYS maintains a reporting system for hospitals. New York State Patient Occurrence & Tracking System ("NYPORTS") hospitals are mandated to report and investigate certain "never events" which should not occur in the absence of negligence.[5] NYPORTS details are generally confidential as part of the quality assurance process but are available to OPMC.[6]

Incoming complaints are investigated and reviewed by supervisory staff and medical professionals. If there is no evidence of an infraction under the misconduct statutes, the case is closed. In 2021, 47% of cases investigated moved forward (Board Report, supra). The subject of the allegations is often offered an informal interview with an investigator. Practitioners are entitled to appear with an attorney and a stenographer at their own expense. Physicians should consult with an experienced health care counsel before attending such an interview. The bane of every lawyer's existence is the client who tells you about what they did after they did it.

Some cases do not move forward for a variety of reasons, such as the complaint is not about a physician, physician assistant or specialist assistant, or the allegations do not set out a case of misconduct under the statute. A committee of the Board, consisting of two physicians and one public member, reviews all possible misconduct allegations and determines whether the matter should move forward toward a hearing.

If the case is deemed to set out a viable allegation, a Department of Health Attorney prepares a Notice of Hearing and a Statement of Charges which set out the allegations against the practitioner. A hearing is held before a Board committee. The practitioner and their attorney are permitted to produce witnesses and evidence at the committee hearing presided over by an Administrative Law Judge who issues Findings of Fact & Conclusions of Law. The committee also has the power to impose a penalty, if warranted. This may include a license suspension, a revocation of license, practice monitor or a fine up to $10,000 per violation.[7] Pursuant to the Board's report, 77% of the cases were deemed "serious," warranting a suspension, revocation or restriction on licenses. According to OPMC statistics, many cases are settled by agreement with the practitioner entering into a consent order.

If either side is dissatisfied with the decision of the Hearing Committee, the side may appeal to an Administrative Review Board ("ARB"), consisting of five members, three physicians and two public members. It is prudent to advise clients to think carefully about an appeal. The ARB may reverse the decision of the Hearing Committee or reduce or increase the penalty. In 2021, ten appeals were heard by the ARB and all determinations were upheld. In two cases, the penalty was decreased and in four of the ten cases, the penalty was increased.

Admissibility—Can I Use It in My Case?

One of the most common questions from attorneys representing malpractice plaintiffs is whether the decision of OPMC can be entered into evidence at trial. The mere existence of a complaint is confidential. If the complaint results in a formal action, the information becomes public. Counsel still must consider whether the action is relevant to their case and the allegations of negligence. Official public records relating to the actions taken by a physician while treating the plaintiff would be fair game in the absence of a contrary ruling by a judge based on the information being highly prejudicial or some other grounds. A more likely scenario is the effort by counsel to use a reported action against a physician from a prior encounter as evidence of the practitioner's lack of care or negligent practice. This becomes a matter for the court to determine.

A case on point is the oft-cited *Matter of Brandon's Estate*[8] which holds that "A general rule of evidence, applicable in both civil and criminal cases is that it is improper to prove that a person did an act on a particular occasion by showing that he did a similar act on a different unrelated occasion" Certain exceptions to this rule…have been recognized when for example, the evidence of other similar acts is offered to help establish motive, intent, absence of mistake or accident, a common scheme or plan, or identity, *Matter of Brandon's Estate, supra*.

The circumstances of the case may have opposing counsel trying to enter "prior acts" as demonstration of the physician's history of careless practice into evidence. In *Mazella v. Beals*,[9] the defendant physician treated the plaintiff's decedent over many years for obsessive compulsive disorder and major depression. The patient's visits to the doctor were few and far between. The doctor continued to renew prescriptions for Paxil (an SSRI medication used to treat depression) over a period of ten years without examining the patient. Ultimately, after a particularly bad episode, the patient took his own life. The case was also unusual in that, at trial, the defendant doctor admitted that his care departed from good and accepted practice but argued that intervening acts severed the causal connection.

Defendant filed a Motion in Limine, seeking to prevent the plaintiff from questioning the doctor about a prior consent order with OPMC. Motion was denied and the jury returned a $1,200,000 verdict. On appeal, the 4th Department affirmed.[10] The Court of Appeals reversed on the basis that the trial court committed reversible error in allowing the defendant to be questioned about the contents of a prior OPMC consent order which only distracted the jury from the central issues in the case.

Citing *Matter of Brandon, supra* "It is improper to prove that a person did an act on a particular occasion by showing that he did a similar act on a different unrelated occasion…The Consent Order was nothing more than evidence of unrelated bad acts,

the type of propensity evidence that lacks probative value concerning any material factual issue…unpersuaded by plaintiff's claim that the evidence was admissible to impeach defendant's credibility."

Good Faith Complaints

In the life cycle of representing physicians and other professionals, there comes a time when counsel is asked if they should sue the plaintiff for filing a frivolous claim. The answer is almost always that this is a very bad idea. In an OPMC case, the identity of the complainant to OPMC is confidential, however, in many cases, the identity may be evident, and the aggrieved doctor may be tempted to retaliate.

Dr. Robert Haar, an orthopedic surgeon, provided treatment to several patients and billed Nationwide Mutual Fire Insurance Co. for services rendered. Nationwide denied one claim and partially denied several others. Subsequently, the company filed a complaint with OPMC who investigated but took no action against Dr. Haar. The physician, feeling aggrieved by the complaint, filed suit against the insurance company for filing a complaint in "bad faith," basing his complaint on the Public Health Law § 230 (11)(b) which provides protection against liability for complaints in "good faith" The case was removed to federal court by the defendant and the district court (Kaplan, J.) dismissed the case upon finding that the Public Health Law created no right of action for bad faith allegations.

Upon appeal, the 2nd Circuit reviewed the allegations de novo and in a detailed analysis of state law, noted that the 2nd Department in *Elkoulily v. NYS Catholic Health Plan* found no private right of action in the section relied upon by the plaintiff.[11] However, the First Department, albeit with minimal analysis, reached the opposite conclusion in *Foong v. Empire Blue Cross*.[12]

Due to the split, the 2nd Circuit certified the following question to the NYS Court of Appeals: "Does NY PHL 230 (11) (b) create a private right of action for reporting in bad faith to the Office of Professional Medical Conduct?"

The Court of Appeals responds in the negative. The court notes that the statute in question requires certain entities to file complaints but allows others to permissively file complaints. The plaintiff concedes that the statute does not expressly create a cause of action but rather the cause of action is implied. Judge Stein notes that in this situation, the court looks at three factors: whether the plaintiff is in a class for whom this right may be implied; whether it is consistent with the legislative scheme; and whether it would promote the legislative purpose. In this case, the plaintiff fails on all three prongs. The statute in question was added to protect the complainant, not the subject of the complaint. The court also notes that the relief requested by plaintiff would not promote any legislative purpose and given the expressed purpose of the statute pursuant to the sponsors memorandum, is not consistent with the legislative intent.

> "In sum, Public Health Law § 230(11)(b) was not enacted for persons similarly situated to plaintiff, and a private right of action is inconsistent with the legislated purpose and broader statutory scheme."[13]

Conclusion

The Board of Professional Medical Conduct and its Office for Professional Medical Conduct operate a statutorily mandated process providing oversight for physicians and physician assistants. A client who receives any communications from OPMC should contact an attorney familiar with the process immediately for advice and representation. There is a tendency among highly educated professionals to believe that they can simply explain what happened and the problem will go away. An OPMC investigation is just as serious as a court proceeding and may result in significant sanctions up to and including loss of license. It should be taken seriously.

1. NYS Educ. Law 6530, et. Seq.
2. https://www.health.ny.gov/professionals/doctors/conduct/annual_report/2021/docs/report.pdf.
3. 42 U.S.C. 11101-11154, 45 C.F.R. § 60.1 (2024).
4. NYS Ins. Law § 315.
5. NYS Public Health Law § 2805-L.
6. NYS Public Health Law § 2805-M.
7. NYS Public Health Law § 230-A.
8. 55 N.Y.2d 206,210,211 (1982).
9. 27 N.Y.3d 694 (2016).
10. 122 A.D.3rd 1358 (4th dept. 2014).
11. 153 A.D.3rd 768, 772 (2d Dept. 2017).
12. 305 A.D.2d 330 (First dept 2003).
13. 115 N.Y.S.3d 197.

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