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Understanding, Forecasting and Challenging Penalties Issued by the Board of Medical Examiners

by Alma Saravia and John Zen Jackson

The Legislature created the New Jersey State Board of Medical Examiners (BME) to regulate the more than 33,000 physicians, podiatrists, and other health professionals in New Jersey. The BME has broad statutory and regulatory authority over its licensees, including the imposition of discipline. Very few cases result in the revocation of a license; the BME, like other licensing boards, has power to impose a range of penalties.

As detailed below, most licensees enter into a consent order rather than fight the charges at a hearing or through judicial review. The BME has imposed disciplinary sanctions notwithstanding that there was no patient harm. The New Jersey Supreme Court has confirmed the proposition that the BME may even revoke a physician's license despite the lack of direct patient harm.

Board of Medical Examiners Background

The BME is authorized to investigate any questionable conduct of a licensee, and may deny, suspend, or revoke a license. The governor may appoint 21 members to the BME, including: 12 physicians, a podiatrist, a bioanalytic lab director, a physician's assistant, a nurse midwife, a representative of the governor, the commissioner of health and senior services, and three public members. At the end of 2005, Acting Governor Richard Codey appointed 10 new members to the BME.

In 2001, the Legislature granted the BME additional powers to investigate and discipline physicians.[1] It created the key position of educational director, with the responsibility of overseeing the continuing medical education program and the monitoring and remediation program for physicians deemed to have deficient skills.[2] These expansions in the scope of the BME's authority are a response to well-publicized concerns about patient safety and the perception that physicians can move from state to state without being subjected to disciplinary action.

A survey covering 30 years of BME records was published in the 2003 *New Jersey Law Journal*. It found that the license of only one in three physicians who had repeatedly committed malpractice was revoked in that time period.[3]

Overview of the Disciplinary Process

Information regarding possible physician misconduct may come to the BME in a number of ways. These include a report

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of a criminal conviction by a court clerk, as well as reporting of adverse privilege actions or malpractice settlements and judgments by healthcare entities or insurers. A patient, another healthcare practitioner, or an insurer, may make a complaint. Typically, the BME sends the physician a letter requesting a written response. Many disputes can be resolved if a detailed explanation of the facts and the applicable regulations or standards of care are submitted to the BME.

The BME is permitted to conduct a comprehensive investigation with investigators. The BME may inspect a physician's office, subpoena medical records, demand a statement under oath or require the physician to appear before a committee to respond to questions. A court reporter will be present to transcribe the physician's testimony under oath. The BME relies heavily upon comments made to an investigator or before a committee when deciding whether to bring a formal charge.

The BME is authorized by law to find that there is no cause for disciplinary action. On the other hand, it may immediately file a complaint with an order to show cause for a temporary license suspension if it determines that a physician is an imminent danger to the public. If the BME determines that the complaint warrants corrective action but is insufficient to meet the minimum proof requirements for initiating a public disciplinary action, it may issue a letter of warning, reprimand, or censure pursuant to N.J.S.A. 45:1-22. The most likely course of action is that the BME seeks to negotiate a consent order with the physician.

When the matter is not settled with the entry of a consent order, the BME takes formal legal action by filing a complaint that is transmitted to the Office of Administrative Law (OAL) as a contested case for a hearing. The administrative law judge (ALJ) makes findings of fact and conclusion of law, and recommends disciplinary and financial sanctions. The BME prevails if it proves its case by a preponderance of the evidence.[4] The BME may adopt, reject or modify the ALJ's recommendation in a formal order, after reviewing the record and considering any exceptions, objections, and replies filed by each party pursuant to N.J.S.A. 52:14B-10(c). In some instances, the BME has rejected the ALJ's findings or conclusions.

Statutory Framework for Professional Discipline

In enacting the Uniform Enforcement Act, the Legislature authorized the BME to "suspend or revoke" a license in the circumstances of a broad range of statutorily identified misconduct.[5] For physicians as well as other licensed professions and occupations, the grounds for the discipline of revocation or suspension include:

- Dishonesty, fraud, deception, misrepresentation, false promise or false pretense;
- Gross negligence, gross malpractice or gross incompetence that damaged or endangered the life, health, welfare, safety or property of any person;
- Repeated acts of negligence, malpractice or incompetence; and
- Engaging in professional misconduct "as may be determined by the board."

In addition, revocation or suspension may be imposed when there has been a revocation or suspension in another state for reasons consistent with the statute, or where a licensee has been convicted of or engaged in acts constituting any crime or offense involving "moral turpitude or relating adversely" to the practice of medicine. Such discipline also may be dispensed if a licensee violated or failed to comply with the provisions of any act or regulation administered by the BME. The statute contains additional specifications of conduct warranting revocation or suspension, including impairment from medical cause or substance abuse, as well as other violations of statutory and regulatory provisions.

Some of the grounds for revocation or suspension appear to be nebulous and undefined. However, the cases have rejected challenges to the concepts of "good moral character" or "professional misconduct" as unconstitutionally vague.[6] Indeed, the New Jersey Supreme Court has rejected the assertion that because certain conduct had not been specifically referenced by the Legislature as unprofessional conduct, it could not be the basis for a revocation proceeding. The Court entrusted the licensing body with the authority to define such unacceptable conduct, seemingly even on an *ad hoc* basis.[7]

The distinction between an error that might be negligent and "gross negligence or gross malpractice" is often elusive. The BME may charge a physician with gross negligence, gross malpractice, or gross incompetence.[8] It also may discipline a physician for repeated acts of negligence, malpractice or incompetence.[9] To understand the elements of these offenses one must review not only case law but also decisions of the OAL and BME consent orders.

The exact meaning of the terms "gross malpractice" and "gross negligence," which connote something beyond *mere* negligence or malpractice, is left to the judgment of the BME.[10] Repeated acts of negligence or gross negligence also may provide a basis for discipline by the BME.

Unlike a civil malpractice action,

when the negligence standard is used in a disciplinary setting resulting damages are not necessary. Indeed, the OAL has repeatedly held that "findings of gross and repeated negligence in the context of disciplinary hearings need not be accompanied by proof of actual harm to any patient."[11] On the other hand, "medical malpractice alone is not a basis for the Board of Medical Examiners to interfere with a physician's license to practice."[12]

As the role of the BME is to protect the public from shoddy and incompetent providers of medical services, rather than to provide a forum for the recompense of injury, the BME need not find that injury followed upon gross or repeated acts of malpractice, negligence or incompetence. In part this is because the BME must act to protect the public from future misconduct by a physician shown to have committed significant acts of negligence and/or gross negligence in the past.

Some of the decisions have dealt with distinctions drawn between *gross* negligence, malpractice or incompetence under N.J.S.A. 45:1-21(c), and *repeated* acts of negligence, malpractice or incompetence pursuant to N.J.S.A. 45:1-21(d).[13] Ordinary negligence, malpractice or incompetence has been held to include conduct involving a failure to exercise the degree of care, knowledge and skill ordinarily possessed and exercised in similar situations by the average member of the profession practicing in the field[14] or when there has been a deviation from normal standards of conduct.[15]

Gross negligence, malpractice or incompetence has been construed to mean conduct "beyond such [deviation from normal standards of conduct]," although just "how far beyond has been left to the judgment of the Board."[16] Conduct rising to the level of gross activity also has been described by the New Jersey Supreme Court as the sort of activity that represents a conscious and reckless indifference to the health and safety of a patient, or a patently wide departure from accepted standards of care and treatment.[17]

To establish a violation of N.J.S.A. 45:1-21(d), the proofs must demonstrate repeated acts of negligence, malpractice or incompetence. Unless the characterization as gross is present, a single act will not give rise to a statutory transgression. However, in order to find a violation of N.J.S.A. 45:1-21(c) or N.J.S.A. 45:1-21(d), there is no requirement that proof of injury or harm to the patient be shown.[18] Although a 1980 BME decision seemed to require a finding that there be a "compensable injury" in order to establish a violation, this view was subsequently repudiated by the BME itself.[20]

It is long established that licensed physicians must be qualified, competent, and honest, and must conduct themselves in a professional manner.[21] It has been the BME's position that there is no need to prove *mens rea,* and that to establish a violation of N.J.S.A. 45:1-21(b) involving fraud, misrepresentation, or other dishonest or deceptive conduct, the traditional common law elements need not be shown. Findings of deception, fraud, false pretense and misrepresentation, or negligence do not require proof of willfulness or intent to deceive. A claimed absence of intent may be considered only in mitigation of penalties.[22] However, this legal position has not been subjected to meaningful judicial review.[23]

Possible Penalties

The filed consent orders as well as final orders in contested matters, are available on the BME's website dating from the 2002 time period to present.[24] A review of 150 of these consent orders reflects the wide range of disciplinary actions imposed upon licensees—including those where there were similar allegations. There is no consistent and predictable pattern.

A typical consent order includes a stayed or active period of suspension, attendance at an ethics or record-keeping course, proof of clinical competence, participation in the Professional Assistance Program (for physicians with substance abuse issues) and assessment of costs and penalties. Less than 10 percent of those consent orders resulted in the revocation of the physician's license. All consent orders must be reported to the National Practitioners Data Bank.

When there is proscribed misconduct, in addition to revocation or suspension, the Legislature authorized "additional or alternative penalties" to revocation or suspension in the form of letters of warning, reprimand or censure, as well as civil monetary penalties and orders for corrective action.[25] The civil monetary penalties are currently $10,000 for the first offense and $20,000 for the second and "each subsequent violation."[26] Under the Uniform Enforcement Act, each act in violation of the statute or applicable regulations constitutes a "separate violation" and is to be deemed a "subsequent violation" when there has been a prior order entered. There also is a subsequent violation when the person is found in a single proceeding to have committed more than one violation of any regulatory provision.

While authorizing a range of discipline and penalties, the Legislature did not provide any guidelines for where on the continuum of discipline a decision should be made. That decision was left to the discretion of the administrative agency or regulatory board. That decision, however, is subject to judicial review. The realistic expectation is that

such review will be limited and deferential. As with any state agency, the basic paradigm is whether there is substantial credible evidence to support the findings, and whether the decision is arbitrary and capricious.

The act regulating professional conduct is deemed remedial, and should be enforced in such a way as to remedy wrongs that may have been committed by a licensee in the past, and to prevent the commission of future wrongs. The primary purpose of sanctions such as license suspensions is to reform and rehabilitate, and to protect the public until rehabilitation has been achieved. Punishment is not a primary purpose of the legislative design.[27] Nonetheless, even brief suspensions can bring about catastrophic collateral consequences.

Judicial Review

In *In re Polk*,[28] the Supreme Court discussed the standard for judicial review of a sanction imposed by an administrative agency such as the BME. The court has the inherent authority to alter a sanction in order "to bring the agency into conformity with its delegated authority." It would "interpose its views only where it is satisfied that the agency has mistakenly exercised its discretion or misperceived its own statutory authority." Ultimately, the Court summarized the test in reviewing administrative sanctions as "whether such punishment is 'so disproportionate to the offense, in the light of all the circumstances, as to be shocking to one's sense of fairness."'

In *Polk*, the Court concluded that the sanction of revocation for a physician who had sexually abused female patients was within the BME's statutory discretion. However, it concluded as "a matter of simple fairness" that the case had to be remanded because the BME had reached a fixed determination without giving sufficient consideration to mitigating circumstances. In that regard, the Supreme Court's comment in *Polk* is important:

> It is therefore an essential element of the legislatively designed administrative regulatory scheme that the Board, in a disciplinary proceeding, scrupulously consider all factors relevant to continued licensure. It must, furthermore, meticulously weight the public interest and the need for the continued services of qualified medical doctors against the countervailing concern that society be protected from professional ineptitude.[29]

It is unusual for a court to overturn the sanction imposed by a medical board. It was done in *Polk*. It also was done in *In re Fanelli*,[30] where the BME had revoked the physician's license based on his having pled guilty to a conspiracy charge involving funds in a pension fund. The BME had failed to make an appropriate inquiry regarding the "knowledge, whether actual or constructive" of the embezzlement, which had been done by someone else. The Court also directed that there be consideration of "the relationship between his crime and the activities regulated by the Board."

In reversing the order of revocation and remanding it to the BME for further consideration, the Supreme Court commented:

> the Board retains the discretion to determine, subject to appellate review, whether discipline should be imposed and, if so, the quantum of that discipline.[31]

These were both procedural reversals, not done on the merits of the substantive challenge as excessive punishment. The Supreme Court reiterated its adherence to the "shocking" standard in its more recent decision of *In re Zahl*.[32] There, the physician had been found to have engaged in a multitude of dishonest acts, including billing violations and recordkeeping irregularities, as well as misstatements in a personal disability income insurance claim.

In an unreported opinion the Appellate Division had upheld the BME's findings of misconduct but had concluded that the punishment of revocation was "excessive" and "unduly harsh," especially in light of the conceded absence of patient harm from the physician's conduct. The Supreme Court disagreed and remanded the matter to the BME for entry of an order revoking Dr. Zahl's license.

It rejected without any extended analysis the argument that because other physicians who had engaged in fraudulent behavior and been subject to license revocation also had caused patient harm, the discipline in his circumstance was disproportionate. The Court stated that the presence of patient harm in those other matters did not make it "inappropriate" for the BME to revoke the license. The BME did not make its decision "in a vacuum," but based on "the individual circumstances of his case."[33]

A result may be shocking to one's sense of fairness if the sanction imposed is so grave in its impact on the individual subjected to it that it is disproportionate to the misconduct, incompetence, or moral turpitude of the individual, or to the harm or risk of harm to the public generally or threatened by the derelictions of the individual. It would seem that comparing the misconduct at issue with the disciplinary outcomes of other licensees with data that might be obtained from the BME's own decisions should pro-

vide the groundwork for making an argument regarding excessive or disproportionate penalties. However, the case law does not support that intuitive sense.

As in *Zahl*, other courts have rejected the attempt to make such a comparative analysis. For example, in the New York decision of *Abdelmessih v. Board of Regents*,[34] the court stated that "penalties need not be meted out with mathematical precision." Showing that an agency had imposed "differing penalties among licensees for ostensibly similar transgressions" did not satisfy the "shocking" standard.

The variation on that argument that less severe penalties had been imposed on supposedly more egregious conduct also has failed. Indeed, the equating and ranking of types of misconduct may be beside the point. The courts have applied the tenet that "each case must be judged on its own facts and circumstances."[35]

There are rare instances in which a court has overturned a penalty as truly shocking. A surprising number of them have been in New York, which also uses the "shocking to one's sense of fairness" test.

The penalty of revocation was "excessively harsh" in *Sarosi v. Sobol*.[36] There, an obstetrician-gynecologist had pleaded guilty to violating a statute prohibiting placement of a child for adoption. The adoptive parents subsequently killed the child. The reviewing court concluded that the penalty was excessively harsh, arbitrary, and capricious. It also noted that the physician was "an extremely competent and highly regarded physician with a heretofore unblemished record" who had violated a relatively obscure statute. The court remanded the matter for reconsideration.

In *Colvin v. Chassin*,[37] the court found a revocation "excessive," where the physician had demonstrated deficiencies in his performance as a radiologist, but there was no issue regarding his competency as a general practitioner. The court found that a limitation on the scope of the physician's practice would have been appropriate.

The penalty of revocation was reversed in *Sarfo v. DeBuono*.[38] There, a pediatrician had filed a false report with a hospital regarding his Medicaid status by answering no to a question regarding suspension from the program. The court noted that "nowhere in the record is there evidence that petitioner's misconduct related to his ability to practice medicine or his skill as a physician."

The court concluded:

> While there is no question that petitioner's error in judgment in misrepresenting his Medicaid status was a serious one that deserves punishment, we do not believe, under the circumstances presented herein, that petitioner's conduct merited the revocation of his medical license.[39]

Similarly, in *Addei v. State Board for Professional Medical Conduct*,[40] the court reversed the revocation of a physician's license. The physician had been charged with sexual misconduct and entering false information on an employment application with a hospital.

The court stated:

> While petitioner's misconduct was serious and merits discipline, we are of the view that this case is one of those rare instances where revocation is "so incommensurate with the offense as to shock one's sense of fairness."[41]

The court reviewed the misconduct and further commented:

> Additionally, there is no direct evidence that patient care was impacted, and nowhere in the record is there evidence that his misconduct related to his ability or skill as a physician, a profession that he has practiced for over 30 years.

More recently, the sanction of revocation was found excessive in *Eley v. Medical Licensure Commission of Alabama*.[42] The charges involved performance of unnecessary diagnostic tests and surgical services, including the use of pain medications. The court rejected the argument that "'it is totally up to the Commission to set the punishment.'" While recognizing the statutory discretion of the regulatory body, the court stated:

> After carefully reviewing the record, we agree with the finding of the trial court that the sanction imposed was too harsh a penalty; we do not agree with the holding of the trial court that it was precluded from acting upon that finding. Because we conclude based on the record presented that the sanction imposed by the Commission revoking Dr. Eley's medical license was excessive and disproportionate to the wrong he committed, that sanction is due to be reversed.

The case was remanded to the agency for "a more appropriate sanction."

Terminology such as "shocking to one's sense of fairness" involves a subjective response to the situation presented. This terminology has persisted for many years, and through many cases. Such language reflects difficulty in articulating an objective standard. There is no simple litmus test. A challenge to the extent of a penalty as excessive or inappropriate is extraordinarily difficult in the absence of procedural or evidential defects in the proceedings charging the misconduct. This is especially the case

when the misconduct is multi-faceted and not an isolated occurrence.

Conclusion

An isolated or insignificant misadventure is not likely to bring a physician under scrutiny by the BME. However, when embroiled in a disciplinary matter, the physician must recognize the need for legal representation in this environment. For example, in an appearance before a BME Preliminary Evaluation Committee, many physicians *volunteer* information in the spirit of being cooperative. This strategy is usually not very effective, and needs to be balanced with an awareness of the potential pitfalls.

There are a number of factors that lead to the reality that most matters commenced before the BME result in the entry of a consent order. Among these is the limited scope and deferential standard of judicial review. While recourse to the courts is theoretically available, it is often illusory. ⚖

Endnotes

1. L. 2001, c. 307 codified at N.J.S.A. 45:9-19.6 and 45:9-19.9.
2. The first education director is Mary Blanks, M.D. She had had a similar position in another state and is an obstetrician-gynecologist by training.
3. Edwards, Bad Doctors do Keep on Practicing, 174 *N.J.L.J.* 909, 924-25 (Dec. 15, 2003).
4. *In re Polk,* 90 N.J. 550 (1982).
5. N.J.S.A. 45:1-21
6. *In re Polk,* 90 N.J. 550, 575 (1982).
7. *In re Heller,* 73 N.J. 292 (1977).
8. N.J.S.A. 45:1-21(c).
9. N.J.S.A. 45:1-21(d).
10. *In re Kerlin,* 151 N.J. Super. 179, 186 (App. Div. 1977).
11. *In re Caragine,* 2000 WL 1899789 (N.J. Admin. 2000), *quoting In re Rodriguera,* 93 N.J.A.R.2d (BDS) 33, 83, *aff'd,* 95 N.J.A.R. 2d (BDS) 39 (App. Div. 1995).
12. *In re Daiter,* 2003 WL 23012234 (N.J. Admin. 2003), *citing State BME v. Weiner,* 68 N.J. Super. 468, 483 (App. Div. 1961).
13. *In re Goldstein,* 2005 WL 1190410, at *51-52.
14. *Schueler v. Strelinger,* 43 N.J. 330 (1964).
15. *In re Kerlin,* 151 N.J. Super. 179, 186 (App. Div. 1977).
16. *Id.* at 186.
17. *In re Heller,* 73 N.J. 292 (1977).
18. *Black v. MacMahon,* 130 N.J.L. 323 (Sup. Ct. 1943), *aff'd,* 132 N.J.L. 171 (E. & A. 1944
19. *State Board of Medical Examiners v. Doriety,* 1 N.J.A.R. 210, 221 (1980).
20. *In re Dengrove,* OAL Dkt. No. BDS 1999-84, 13 N.J.A.R. 639, 712 (initial decision Feb. 20 1986; *adopted as modified* Aug. 41986).
21. *In re Polk,* 90 N.J. 550, 574 (1982).
22. *See, e.g., In re Burke,* 2005 WL 544132 at *32 (N.J. Adm. 2005)
23. The Appellate Division found it "immaterial" to conclude whether the state's position that intent was not required was correct because it found substantial evidence of intent in the record. *In re Rodriguera,* 95 N.J.A.R.2d (BDS) 39, 1995 WL 374659 at *21 (App. Div. 1995).
24. The website can be accessed at http://www.state.nj.us/lps/ca/bme/index.html.
25. N.J.S.A. 45:1-22.
26. N.J.S.A. 45:9-25.
27. *In re Friedman,* 13 N.J.A.R. 217, 266 (1990)(*citing Cresse v. Parsekian,* 81 N.J. Super. 536, 548-49 (App. Div. 1963), *aff'd,* 43 N.J. 326 (1964).
28. 90 N.J. 550 (1982).
29. *Id.* at 579.
30. 174 N.J. 165 (2002).
31. *Id.* at 181.
32. 186 N.J. 341 (2006).
33. *Id.* at 357.
34. 613 N.Y.S.2d 971 (App. Div. 1994).
35. *Barad v. State Board for Professional Medical Conduct,* 724 N.Y.S.2d 87, 90 (App. Div. 2001) *quoting Moon Ho Huh v. New York State Department of Health,* 681 N.Y.S.2d 872, 873 (App. Div. 1998).
36. 553 N.Y.S.2d 517 (N.Y. App. Div. 1990).
37. 625 N.Y.S.2d 351 (App. Div. 1995).
38. 652 N.Y.S.2d 852 (N.Y. App. Div. 1997).
39. *Id.* at 854.
40. 717 N.Y.S.2d 388 (N.Y. App. Div. 2000).
41. *Id.* at 391.
42. 2003 WL 22182394 (Ala. Civ. App. 2003).

Alma Saravia *is a shareholder of Flaster/Greenberg in Cherry Hill. From 1992 to 1994 she was the governor's designee to the New Jersey State Board of Medical Examiners.* ***John Zen Jackson*** *is a principal of Kalison, McBride, Jackson & Murphy, P.A. in Warren. He is certified by the Supreme Court of New Jersey as a civil trial attorney.*