**Testimony of Board Defense Attorneys**

Proposed Regulations of the Board of Registration in Medicine, 243 CMR 1.00

Public Hearing on March 1, 2017

**Introduction**

The undersigned 19 attorneys have been representing physicians before the Board of Registration in Medicine for a combined 430 years, one as far back as 1976. We include a former Board Chair and a former Board Vice-Chair.

We support the Board’s mission: to protect the public. The context of this testimony is our concern that the Board measures that mission’s success only in terms of the number of physicians it can discipline, and whether it can impose the harshest discipline possible that will be upheld by the Supreme Judicial Court.

We are troubled by the Board’s treating due process as an obstacle rather than a tool for getting to the truth. To truly protect the public, the Board should only want to base its actions on accurate facts. That is why due process matters: the Board cannot determine accurate facts if it undermines the accused’s opportunity to get not only notice and an opportunity to be heard, but *fair* notice and a *fair* opportunity to be heard.

Below, we recount specific examples of the regulations’ violations of the U.S. Constitution, the Board’s enabling legislation, U.S. Supreme Court and Supreme Judicial Court rulings, as well as a directive from the Supervisor of Public Records.

The Board currently has a robust set of regulations that already give the Board tremendous advantages in what should be an evenhanded process. If there is any theme to the proposed regulations, it is that the Board wants more advantages, while continuing to skate around legal and constitutional requirements.

The proposed revisions contain changes that might appear innocent and minor enough, but to those who are familiar with the current regulations and understand the workings of the Board, they are alarming. If implemented, these proposals will, ironically, *undermine* public protection.

The following are our specific objections to the proposed regulations.

**1. The Board’s Summary Suspension Regulation is Unconstitutional**

The Board’s Summary Suspension regulation, 243 CMR 10.3(11), provides for a license suspension prior to a hearing, and states, “The Board must provide a hearing on the necessity for the summary action within seven days after the suspension.” The proposed regulations reenact this unconstitutional provision.

In *Barry v Barchi*, 443 U.S. 55, 66 (1979), the New York Racing Board summarily suspended a horse trainer’s license, but the statute allowing such a suspension did not specify a time during which a hearing had to be held, and it gave the Racing Board up to 30 days *after the hearing* to issue a final order adjudicating the case. The U.S. Supreme Court ruled that the statute’s procedure was unconstitutional, on its face and as applied, because it did not assure the licensee “a prompt proceeding **and a prompt disposition of the issues** . . . .” 443 U.S. at 66. (Emphasis supplied).

In contrast, the Board’s summary suspension regulation pretends that *Barry v. Barchi* never existed. While the Board’s summary suspension regulation provides for a prompt hearing within seven (7) days to determine the necessity of the suspension, *the Board has no time requirement for any disposition at all*, much less the “prompt disposition” required by *Barry v. Barchi*. The lack of a disposition time limit renders the Board’s Summary Suspension regulation unconstitutional on its face (as was the statute in *Barry v. Barchi*.) Even worse: in practice, the Board allows several months, and in a recent case over a year, to go by before rendering what is supposed to be a “prompt disposition.” All that time, the physician is deprived of his or her livelihood.

The Massachusetts Legislature knows how to formulate a summary suspension procedure for professional licensees that protects the public, *and* is in full compliance with the constitutional “prompt disposition” requirement of *Barry v. Barchi*, 443 U.S. 55 (1979). It has done so for Psychologists, Social Workers, Allied Health Professionals, Allied Mental Health and Human Services Professionals, Chiropractors and 23 other professions within the Division of Professional Licensure (Office of Consumer Affairs and Business Regulation). Mass. Gen. Laws c. 112, § 65B. The Board of Registration in Medicine is not amongst those Boards covered by § 65B, and its self-determined summary suspension regulation (243 CMR 1.03(11)) contains none of the § 65B safeguards against infringement on an individual’s constitutional rights. The § 65B procedure allows the relevant Board of Registration to take up to 10 days to hold a hearing, but then it must issue a “preliminary written decision” within 10 days of the 10-day hearing. That is “prompt.” Again, one year is not “prompt.” Several months is not “prompt.”

The Board should bring its Summary Suspension regulation into compliance with the U.S. Constitution. It can do so by following the Legislature’s lead applicable to 28 other professional boards, and amend its Summary Suspension regulation to be consistent with Mass. Gen. Laws c. 112, § 65B.

**2. The Board is unlawfully reenacting denial of the physician’s right to see the complaint.**

In its reenactment of 243 CMR 1.03(4) (“Conference”) and (7) (“Order for Answer and Answering”), the Board continues an obnoxious and illegal practice initiated by a prior Enforcement Director: refusing to give the physician a copy of the complaint in advance of requiring a response to it.

The Board is violating its enabling statute, as clearly construed by the Supreme Judicial Court in *Cronin v. Strayer*, 392 Mass. 525, 533 (1984):

The Board of Registration in Medicine has a function similar to the I.P.C. [Impaired Physicians Committee of the Massachusetts Medical Society]. The board's investigations are confidential by statute. However, the policy of confidentiality is inapplicable to a request made by a physician under investigation for the board's investigative records and documents. See G. L. c. 112, § 5, fourth par. 10.

In 2008, 16 attorneys who regularly defend physicians wrote to Dr. John Herman, then Board Chair, to explain the Board’s misconstruction of the law, and the unfairness and inefficiencies resulting from the Board’s practice of withholding the investigative file from the physician. (**Attachment A**) At that time, the attorneys said, “There have even been instances when prosecutors have refused to provide the physician with a copy of the Complaint.” The Board’s Acting Executive Director rejected the attorneys’ concerns. (**Attachment B**) Now, the concern about the occasional withholding of the complaint seems quaint. Since 2008, withholding the complaint has become routine.

Citing *Cronin v. Strayer*, in 2014 the Supervisor of Public Records scolded the Board for refusing to provide the investigative file (which contains the complaint) to a physician who requested it. (See **Attachment C**) Yet, the Board has not changed its practices.

One would have expected in “updating” its regulations as the Board’s Public Notice claims, it would bring them into compliance with the Supervisor of Public Records’ ruling. But instead the Board continues to ignore both the Supervisor of Public Records and the SJC.

**3. Addition of “Remediation” and “Probation, including academic probation” to the Board’s Definition of Discipline.**

**a. Remediation**

The Board proposes to add “remediation” to its definition of “Discipline.”

However, the Board is ignoring that the Legislature has told the Board that “remediation” is not “discipline.” Beginning with the third paragraph of the Board’s main enabling legislation, Mass. Gen. Laws c. 112, § 5, the statute reads (emphasis supplied):

The board is hereby authorized **and directed** to develop and implement, without cost to the commonwealth, a plan for a remediation program designed to improve physicians' clinical and communication skills. **The board shall promulgate rules and regulations for such remediation programs which shall include, but not be limited to, the following provisions**:

(a) **the board shall offer a remediation program to physicians, on a voluntary basis, as an alternative to disciplinary action in appropriate cases as determined by the board**;

(b) the board shall select providers of **remediation** and assessment services for physicians;

(c) the board shall make referrals of physicians to **remediation** and assessment providers, shall have the authority to approve individual remediation programs recommended by such providers and shall monitor the progress of each physician undertaking a remediation program;

(d) the board shall have the authority to determine successful completion of physician **remediation** programs and may make any further orders for probationary monitoring, disciplinary proceedings or other action as it deems appropriate;

(e) the board shall negotiate with insurance carriers, hospitals, health care providers, physicians and other affected parties to establish mechanisms for the funding of the **remediation** programs set forth in this paragraph; provided, however, that said board shall establish terms and conditions under which the primary financial obligation for an individual **remediation** program shall be borne by the affected physician.

To sum up: the Legislature “directed” the Board to offer “remediation . . . as an alternative to disciplinary action in appropriate cases.” The Legislature stated that the Board “**shall promulgate rules and regulations for such remediation programs.”** Instead of following this legislative mandate, the Board chooses instead to do the opposite, to sweep all “remediation” into the definition of “discipline.” One could hardly be surprised if the Legislature finds this regulation not only objectionable public policy, but contemptuous of the Legislature.

Even if there were no statute directing the Board to treat “remediation” as “an alternative to disciplinary action,” this proposed regulation is unwise public policy, as a matter of common sense.

The Board’s “Disciplinary Action” definition is a touchstone of many reporting requirements; the definition reverberates throughout the physician regulatory network of rules, forms, reports and procedures that impact physicians, hospitals and insurance credentialing.

Consider this simple example: adding “remediation” to the definition of “Disciplinary Action” means that a hospital that suggests even a voluntary, brief period of focused evaluation on a physician followed by suggestions for improvement (thus it is “remediation”) will have to report the action to the Board. With the Board’s reputation for being punitive and physicians in justified fear of being reported to the Board, it is far more likely that the hospital will not “remediate” in the first place. Thus, the Board will achieve exactly the opposite of its “public protection” mission.

There are dozens of other similar contexts in which medical schools, graduate medical programs and hospital quality assurance programs, will all be hesitant to “remediate,” because the Massachusetts Board of Registration in Medicine has decreed that “remediation” is a “Disciplinary Action” whether or not the remediating entity believes it is.

But it gets worse. Since the Board by regulation has turned any “remediation” into a “Disciplinary Action,” the hospital, medical school or other remediating entity – to be fair to the physician – will be compelled, or will be required by Bylaws, to offer the physician a full due process hearing, on the record with witnesses, lawyers, cross-examination, etc., before imposing such “Disciplinary Action.” What was once a simple self-correction is no longer possible, because the physician, with a license at stake, will be expected to mount an aggressive defense.

**b. Probation (including academic probation)**

The Board also proposes adding “Probation (including academic probation)” (hereinafter “probation”) to its definition of “Discipline.” This change is also problematic, for reasons similar to the objection to adding “remediation.”

The Board’s proposal to include “probation” is broader than its proposal to include “remediation.” “Remediation” is only included if related “directly or indirectly” to “competence to practice medicine” or “a complaint or allegation regarding any violation of law or regulation . . . or bylaws of a health care facility, medical staff, etc.” “Probation” does not have this limit. Thus, if in college or medical school, due to serious illness, a parent’s illness, due to being a crime victim, or due to one of the infinite and highly personal circumstance that do not reflect on the student’s character or academic abilities, a student’s grades suffered and was placed on academic probation, the Board classifies that academic probation as a “Disciplinary Action.”

This is an intrusive overreach into personal matters that have nothing to do with competence and protecting the public. It is unconscionable to tar a physician with the “Disciplinary Action” label under such circumstances.

As in the case of “remediation,” the Board’s turning “probation” into discipline reportable to the Board imposes drastic external consequences upon academic concerns which can be better solved with academic solutions. The Board will only incentivize medical schools to make drastic alterations to a system which already works, and be hesitant to impose probation.

The Board does not need “academic probation” information to do its job and protect the public. The Board already receives the medical school transcript, which is a complete report of performance in medical school. It does not add one iota of public protection for the Board to receive a report of academic probation, whether related to a highly personal matter having nothing to with the practice of medicine, or even if related to academic performance: the doctor graduated from medical school, and the Board has neither the capacity nor the expertise to act like the medical school accrediting body (like the Liaison Committee on Medical Education) and judge whether or not the medical school “did its job” when it gave a medical degree to a student who had been on academic probation for some limited period of time.

Further, if the Board wants to know when Massachusetts interns and residents are placed on “academic probation,” it should want to avoid the danger of corrupting current systems of academic feedback. Physicians train in an academic setting. Sometimes performance suggests that a period of probation is justified. Some physicians step up their game, do well and work their way off probation. Others do not, their contracts are not renewed and the Board learns about them through current reporting requirements. If every academic probation is reported to the Board, then out of reluctance to subject interns and residents to punishment at the Board, teaching hospitals will have a disincentive to put physicians on probation. As in the case of remediation, doctors threatened with academic probation have a new incentive to exercise their internal appeals. Meanwhile, the benefits of probation will be lost.

**4. Addition as a Ground for Complaint, “conduct which is in violation of the ethical standards of the profession.**”

The Board’s authority to discipline physicians is already wide-ranging. It can discipline physicians for any “misconduct in the practice of medicine.” Through Court decisions it has assumed the authority to discipline physicians for violation of *any* law, whether or not related to the practice of medicine, at least as might reflect on the physician’s having “moral character” satisfactory to the Board. But there is a huge difference between violating laws passed by legislatures, and the Board’s new proposal that it discipline physicians for violating “ethical standards of the profession.” “Ethical standards” can be requirements or aspirational statements adopted by private professional organizations. Physicians may agree or disagree, all with good reasons, over “ethical standards” of private professional organizations.

Physicians’ private professional organizations do not all speak with one voice. They are not all in lockstep on every issue, and physicians should not be subjected to discipline, as the Board would allow, if they have the temerity to disagree with one private professional organization’s version of its “ethical standards.” Is the Board certain that all private professional organizations agree on the ethical standards surrounding physician-assisted suicide? At one time, the AMA was so opposed to HMOs that it expelled physicians who went to work for them.

The Board owes physicians clear advance notice of what is legal and what is illegal, and what is ethical and what is not ethical. The Board has plenary authority to impose rules and standards by regulation, and it should not defer that authority to private professional organizations with which physicians have a right to disagree.

**5. New Definition of “Complaint”**

Under current regulations, a “Complaint” is “a communication filed with the Board which charges a licensee with misconduct.” The proposed regulation defines “Complaint” as “a communication or a document from any source which alleges physician misconduct, malfeasance or any violation of law or regulation pertaining to the practice of medicine or good and accepted medical practice.”

The change means that nobody has to file a complaint for the Board to initiate an investigation: not even a Board member or a member of the staff. The staff in the Enforcement Division can commence any investigation of anything: based on “fake news” posted on Facebook, or based on a whim. While the Board’s authority to investigate has always been extremely broad, at least someone had to take the initiative and put his or her name on a complaint. With the new definition, there is no record and no accountability for staff decisions as to which doctors the Board chooses to investigate and why.

**6. Quorum Requirement**

The Board has seven members. It proposes to include vacancies in its quorum requirement. Thus, if the Board has two vacancies, four members will still be required to make a quorum. Given times in the past when the Board has had difficulties maintaining a quorum, the Board should explain its rationale for this change.

**7. Failure to Provide Legally Required Public Notice of the Proposed Regulations**

The Public Notice for this hearing was issued pursuant to M.G.L. c. 30A, § 2, which states (emphasis supplied):

The notice **shall** refer to the statutory authority under which the action is proposed; give the time and place of the public hearing; **either state the express terms or describe the substance of the proposed regulation**; and include any additional matter required by any law.

The Board’s Notice for this hearing does not comply with M.G.L. c. 30A, § 2. The Notice does not state the express terms of the regulation, and the sum total of its description of the “substance of the proposed regulations” is this:

These amendments will update terminology and remove outdated language and requirements to make the regulations easier to read and understand. In addition, the proposed amendments delete unnecessary or outdated regulations and update provisions to be consistent with current practice.

The Board’s Notice provides absolutely no “substance” regarding, for example, several major changes that *immensely* broaden the Board’s grounds for discipline, and require hospitals and other reporting entities to report as “disciplinary actions” remediation and academic probation (even if such “remediation” or “probation” was not considered “discipline” by the entity reporting it).

The Board’s failure to provide required legal notice of its proposed regulations has kept the public and the profession ignorant of major proposed regulatory changes.

These proposed changes, if finalized by the Board, will not be valid, because the Board failed to comply with the notice requirements in M.G.L. c. 30A, § 2.

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Thank you for this opportunity to comment on the proposed regulations.

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