

COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Division of Administrative Law Appeals

Board of Registration in Medicine,
Petitioner

Docket No. RM-15-648

v.

Sheldon Schwartz, M.D.,
Respondent

Appearance for Petitioner:

James Paikos, Esq.
Board of Registration in Medicine
200 Harvard Mill Square-Suite 330
Wakefield, MA 01880

Appearance for Respondent:

Pro se

Administrative Magistrate:

Bonney Cashin

Summary of Recommended Decision

Sheldon Schwartz, M.D. committed misconduct through his disruptive behavior on two occasions. 243 CMR 1.03(5)(a)(18). His disruptive behavior also demonstrates that he has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *Levy v. Bd. of Reg. in Med.*, 378 Mass. 519 (1979).

RECOMMENDED DECISION

Introduction

On December 4, 2015, the Board of Registration in Medicine issued a Statement of Allegations charging Sheldon Schwartz, M.D. with misconduct in the practice of medicine, lack of good moral character, and conduct that undermines the public

confidence in the integrity of the medical profession. The Board sought to discipline him for disruptive behavior on multiple occasions.

First Administrative Magistrate James P. Rooney held a prehearing conference on February 1, 2016. Discovery and prehearing motion practice followed.

I held a hearing on May 9, 10, 11, 12, 23, and June 1, 7, and 28, 2016, which was transcribed. I admitted 59 exhibits into evidence, marked P1-26 and R1-23, 25-27, 29, 30, 32-36.¹ The following witnesses testified for the Board: Kathryn Patoulidis, R.N., Beverly Penhallurick, Cheryl Grau, Medhat Migeed, M.D., Michelle McIntosh, R.N., Jerry Felson, M.D., Jennifer Moran, Magdalene Pique, James Rollins, and Krishnaswamy Gajaraj, M.D. Dr. Schwartz testified on his own behalf² and also offered testimony from Margaret Reid, Ashley Martell, R.N., Kathleen Hoffman, N.P., Veronica Kpodo, R.N., Frank Barnes, Jr., and Edith Rathbone, Esq.³ I issued oral rulings on several motions filed during the hearing.⁴

Both parties filed post-hearing briefs⁵ and Dr. Schwartz filed a response to the Board's brief. The record closed on October 17, 2016.

FINDINGS OF FACT

Based upon the testimony and other evidence in the record and the reasonable inferences from them, as well as my assessment of witness credibility, I make the following findings of fact:

¹ The document Dr. Schwartz proposed to offer and numbered as 36 was not admitted and remains marked for identification. Tr. VII: 802-804. The document marked as Ex. 36 was offered during the hearing. Tr. VII: 952.

² Bharanidharan Padmanabhan, M.D., filed a limited appearance so that he could question Dr. Schwartz on direct examination. 801 CMR 1.01 (3).

³ On May 20, 2016, Robert E. Harvey, Esq. filed a limited appearance with a motion for a protective order concerning the testimony of Ms. Rathbone, a former Board employee. Tr. VI: 751-752.

⁴ Tr. III: 366-369; Tr. VI: 746-753.

⁵ Dr. Schwartz filed an affidavit of Douglas K. Kinan with his brief. I did not consider the affidavit as evidence, which described Mr. Kinan's assessment of a portion of the hearing he observed.

1. Sheldon Schwartz, M.D. graduated from New York University School of Medicine in 1970.⁶

2. Dr. Schwartz has been licensed to practice medicine in Massachusetts under certificate number 81429 since 1995.

3. In 2012, Dr. Schwartz entered into a Consent Order with the Board, in which he admitted to violating the Board's Disruptive Behavior Policy. (Ex. P2.)

4. Dr. Schwartz was reprimanded by the Board on September 19, 2012. (Ex. P2.)

5. Dr. Schwartz was employed as an internist by Arbour-HRI Hospital, a psychiatric hospital in Brookline, Massachusetts, from June 9, 2005 until June 19, 2013. (Tr. VI: 844-845; Tr. VII: 943; Ex. P3.)

6. Dr. Schwartz was very good with patients. He is a "brilliant" doctor. (Tr. III: 387; Exs. R3, R19.)

February 28, 2013 Meeting

7. On February 28, 2013, Arbour-HRI's senior management were at a daily "flash meeting" to review and discuss admissions, discharges, clinical issues, and other matters that occurred during the prior 24 hours. (Tr. I: 139; Tr. II: 129-130).

8. Neither Arbour-HRI's CEO nor CFO attended the meeting that day. (Tr. I: 132, 163; Tr. II: 287; Tr. III: 401.)

9. The meeting room was within the executive suite and next to the office of Beverly Penhallurick, executive assistant to the then-CEO, Patrick Moallemian. (Tr. I: 129, 131; Ex. R17).

⁶ Findings of Fact 1-4 are based on the Respondent's Answer to the Petitioner's Statement of Allegations.

10. The executive suite was separate from the main hallway for privacy. (Tr. III: 395-396).

11. The witnesses who attended the meeting were: Kathryn Patoulidis, R.N., Beverly Penhallurick, Cheryl Grau, Michelle McIntosh, and Krishnaswamy Gajarj, M.D. (Tr. I: 59, 73, 131, 160-161; Tr. II: 286.)

12. Dr. Schwartz, who did not usually attend the flash meetings, knocked and came into the room while the meeting was wrapping up. (Tr. VII: 912-913.)

13. On that day, Arbour-HRI's computerized medical records system was offline in order to fix an unexpected maintenance problem, and Dr. Schwartz wanted to discuss the administration's response to the staff's lack of access to patient records. (Tr. V: 600-601; Tr. VII: 399; Tr. VIII: 954-955).

14. Dr. Schwartz was particularly concerned because he and other staff did not have access to the back-up of prior days' records for inpatients. (Tr. V: 600-601, 630-631; Tr. VII: 957, 962-963).

15. Paper charting was in place for recording interactions with patients that day. (Tr. V: 664-665; Tr. VII: 961.)

16. Dr. Schwartz also was concerned about the impact of an influx of new patients. He told those in the meeting room that admissions should be closed. (Tr. VII: 968.)

17. Dr. Schwartz was a voice for the medical staff and for patient safety. He usually was conversational and appropriate during meetings, but not on February 28, 2013. (Tr. I: 145, 154, 156.)

18. When speaking to his colleagues, Dr. Schwartz was upset. (Tr. I: 130, 138; Ex. R17.)

19. He also was agitated, and rather loud. (Tr. I: 130, 161; Ex. R17.)

20. Dr. Schwatz spoke passionately; he was not vulgar and swearing. (Tr. I: 140.)

21. Ms. Penhallurick left the meeting room and went to her office to call Mr. Moellemian and tell him what was happening at the meeting. (Tr. I: 132; Ex. R17.)

22. Michelle McIntosh, R.N., a nurse executive at Arbour-HRI at the time, led Dr. Schwartz away from the executive suite, into the hallway and down a nearby flight of stairs. (Tr. II: 295; Tr. VII: 970; Ex. R11.)

23. She was trying to get Dr. Schwartz to meet with the CFO, James Rollins, who was downstairs working on the computer issue. (Tr. II: 295; Tr. III: 407; Ex. R11.)

24. After leaving the meeting room and while in the hallway outside the executive suite, Dr. Schwartz called Ms. McIntosh a bitch. (Tr. I: 131; Tr. II: 287; Tr. VIII: 1120-1122; Ex. R17.)

25. No one else was in the hallway at the time, and it is unlikely that those in the meeting room heard what he said. (Tr. I: 130-131, 138; Ex. R17.)

26. Ms. McIntosh recalled few details of her interaction with Dr. Schwartz on that day. (Tr. II: 289-302.)

27. Dr. Schwartz acknowledged he told Ms. McIntosh she was acting like a bitch, by which he meant unprofessionally. (Tr. VIII: 916-917, 971, 1120-1122; Ex. P22; Answer.)

28. Referring to a colleague as a "bitch," including stating she was acting like a bitch, is disruptive behavior. (Tr. II: 322; Tr. V: 647-648, 676, 692, 728.)

29. As Dr. Schwartz and Ms. McIntosh walked along the hallway downstairs, Mr. Rollins, the CFO, could hear voices as they approached, but did not recognize who was speaking or what was said. (Tr. III: 407, 410-411.)

30. Mr. Rollins did not hear what happened upstairs at the meeting; Ms. McIntosh told him when she and Dr. Schwartz came into the room. (Tr. III: 407-410.)

31. Cheryl Grau, a social worker and the clinical services director at Arbour-HRI, was briefly part of the meeting downstairs. (Tr. I: 184; Tr. III: 406.)

32. She left soon after Dr. Schwartz told her she was "corporate" now and that he could buy and sell her a million times. (Tr. I: 163-164; Tr. VII: 975; Ex. P5.)

33. Dr. Schwartz admitted he said this to Ms. Grau. He did not intend for his comment to be demeaning or insulting. He viewed the statement as an acknowledgement that he was well-to-do, and as appropriate under the circumstances. (Tr. VII: 975; Tr. VIII: 1125-1129; Ex. P22.)

34. Dr. Gajaraj came into the room while Dr. Schwartz and Mr. Rollins were speaking. (Tr. III: 406, 422.) Dr. Gajaraj's recollection of the flash meeting and its aftermath was poor. (Tr. IV: 509-521.)

35. Mr. Rollins and Dr. Schwartz spoke for about an hour-and-a-half. Mr. Rollins tried to understand Dr. Schwartz's concerns, but had some difficulty doing so until Dr. Schwartz became less upset. (Tr. III: 400-402.)

36. Mr. Rollins had little to do with the medical side of Arbour-HRI's administration. He handled financial matters at another facility and was at Arbor HRI only one or two days each week. (Tr. III: 399.)

37. Dr. Schwartz apologized to patients attending a group therapy session downstairs because he was told they had overheard Ms. McIntosh and him in the hallway. (Tr. III: 430.) There is no credible evidence that the patients did overhear them. (Tr. I: 156.)

38. Mr. Rollins dealt with Dr. Schwartz directly on occasion. (Ex. R20.)

39. After his conversation with Dr. Schwartz, Mr. Rollins spoke with other administrators and notified staff to stop admissions. (Tr. III: 413-414; Tr. VII: 977.)

May 9, 2013 Meeting

40. On May 9, 2013, Dr. Schwartz called Dr. Gajaraj, who served as Arbour-HRI's Medical Director, about the failure of the psychiatrist on call the previous evening to do a complete medical work up of the patient he was admitting. (Tr. III: 467; Tr. IV 480-481, 498; Ex. P8.)

41. Later that morning, Dr. Schwartz went to Dr. Gajaraj's office to talk further with him about the incomplete work up. (Tr. IV: 484; Ex. R4.)

42. This was not the first time a psychiatrist on call failed to perform a complete medical work up when admitting a patient, and Dr. Schwartz and Dr. Gajaraj had argued about it before. (Tr. VII: 919.) Dr. Schwartz was upset about this because it posed a patient safety issue, and, as the internist on staff, he would have to complete the patient's medical evaluation the following morning. (Tr. IV: 525; Ex. R8.) This was concerning to Dr. Schwartz because multiple patients did not receive the care needed in a

timely way, and he often stayed late to finish his work because of it. (Tr. V: 588-592; Tr. VII: 918-919; Tr. VIII: 1162-1163; Ex. R30.)

43. Dr. Gajaraj yelled at Dr. Schwartz; Dr. Schwartz yelled back and walked out. (Tr. VII: 921; Tr. VIII: 1168-1169.)

44. As a psychiatrist, Dr. Gajaraj was not familiar with or knowledgeable about the practice of internal medicine beyond the basics. (Tr. II: 334.)

45. As was evident from the manner in which they spoke about each other, Dr. Schwartz and Dr. Gajaraj do not get along. They regularly complained about each other. (Tr. II: 259-260; Tr. V: 593, 729; Exs. R8, 10.)

46. Dr. Schwartz and Dr. Gajaraj do not respect each other. (Tr. VII: 921.)

47. Dr. Gajaraj was loud, unprofessional, insulting, abusive, threatening, and harassing toward Jerry Felson, M.D., an on-call physician at Arbour-HRI, and was very loud, inappropriate and unprofessional to nurses. (Tr. II: 325, 326, 343; Tr. V: 635-636, 710-712.)

48. Dr. Gajaraj, who acknowledged that the Board had investigated him, refused to answer questions on cross examination about the complaint, even after instructed by the Magistrate to do so. His Board profile shows no disciplinary action against him. (Tr. IV: 563-565; Tr. VII: 918-920; Ex. P26.)

49. Dr. Schwartz acknowledged that he spoke a little loudly; Veronica Kpodo, R.N. agreed with him. (Tr. V: 719; VII: 936.)⁷

⁷ After listening to and observing Dr. Schwartz over several days of hearing, I would describe his typical volume of speaking as louder than average. His voice rises when he is animated.

May 30, 2013 Incident

50. On May 30, 2013, Dr. Schwartz was finishing his assessment notes on a patient in a treatment room, which also served as his office. (Tr. V: 710-711; Tr. VII: 933; Exs. R8, R14.)

51. On behalf of social worker Allison Ippolito and mental health worker Jen Moran, Veronica Kpodo, R.N. asked Dr. Schwartz if they could use the room for a "johnny search" of a new patient (who was with them). Such searches are a routine safety precaution before a new patient sees a doctor. (Tr. V: 712-713; Tr. IV: 486; Ex. R8.)

52. Dr. Schwartz said simply: "no." He needed to finish his patient's orders, and he expected they would wait. The women took the patient to the solarium bathroom instead. Not using the exam room was technically against hospital policy, although the solarium had been used on other occasions for johnny searches. (Tr. V: 713; Tr. VII: 935; Exs. P12, P15, R14.)

53. When Ms. Ippolito and Ms. Moran returned with the patient to the treatment room, Drs. Gajaraj and Schwartz were arguing loudly outside by the nurse's station area where the patient could hear them. Apparently the argument was about the necessity of medications for a patient. (Exs. P10, P11, P12, P15.)

54. Both Ms. Ippolito and Ms. Moran told the doctors there was a patient in the treatment room, and Dr. Schwartz responded: "I don't care." (Exs. P10, P11, P12.)

55. Both Ms. Ippolito and Ms. Moran signed statements on May 30, 2013 about the incident, at the behest of Nicole Kraut, a risk manager at Arbour-HRI, who spoke with them and may also have written their statements. (Tr. III: 371, 376; Exs. P11, P12, R9.)

56. Ms. Grau supervised Ms. Ippolito. After Ms. Grau spoke to Mr. Moallemian, she asked Ms. Ippolito to send him an email about the incident, with a copy to her. (Tr. I: 169, 170-171; Ex. P10.)

57. Ms. Kpodo was asked to provide a statement, but refused to do so because she was afraid it would be used against her. (Tr. V: 715.)

58. At the hearing, Ms. Moran did not recall the events of May 30, 2013 aside from her statement. (Tr. III: 372-373.) She testified reluctantly and had no independent recollection of events.

59. On the following day, Dr. Schwartz admitted to Mr. Moallemian that he was disruptive on May 30, 2013. (Ex. P15.)

60. Dr. Schwartz apologized to Ms. Kpodo and Ms. Ippolito. (Ex. P15.)

61. Dr. Schwartz acknowledged that the patient was upset at overhearing the argument with Dr. Gajaraj. Her care was not delayed. Dr. Schwartz examined her within 45 minutes to an hour of when she arrived on the floor. (Ex. P15.)

May 31, 2013 Incident

62. On May 31, 2013, Dr. Schwartz met with Mr. Moallemian in his office about the incidents on May 30, 2013 involving Drs. Schwartz and Gajaraj. (Tr. VII: 1008; Ex. P14.)

63. Dr. Schwartz and Mr. Moallemian had a tense relationship; they had disagreed in the past and had little respect for each other. (Tr. VII: 1003; Ex. P5.)

64. Magdalene Pique, an Arbour-HRI administrative assistant at the time, was at her desk in the front room of the office suite, outside of Mr. Moallemian's office. The

door to Mr. Moallemian's office was open; the door to the suite was closed. (Tr. III: 390-391, 392.)

65. During the conversation between the doctor and the CEO, which lasted about ten minutes, Dr. Schwartz spoke in an angry, loud voice, and at one point he called Mr. Moellemian an "asshole." (Tr. III: 387-388, 389; Tr. VIII: 1101; Ex. R19.)

66. No one outside of the office suite heard the conversation. (Tr. III: 391.)

67. Dr. Gajaraj was not present. (Tr. III: 391.)

68. Mr. Moellemian summarily suspended Dr. Schwartz on May 31, 2013 for disruptive behavior on May 30. (Tr. VII: 943, 984, 1008-1009; Ex. P14.)

69. Mr. Moellemian gave Dr. Schwartz a letter of suspension prepared in advance, which most likely lead to the tone of the conversation Ms. Pique overheard. (Tr. VII: 1008-1009; Ex. P14.)

70. Dr. Schwartz left Mr. Moellemian's office and walked down the hall toward the lobby. (Tr. VII: 1010.)

71. Maintenance personnel took his parking pass and keys. (Tr. VII: 941.)

72. It is unclear whether Dr. Schwartz was disruptive in the lobby. None of the individuals who interacted with him there testified. (Tr. VII: 938-942.)

73. Dr. Schwartz sent an email to Mr. Moellemian later that day. In it he acknowledged that he was disruptive on May 30 but pointed out that Dr. Gajaraj was also. His tone was alternately indignant and resigned. (Ex. P15.)

Dr. Schwartz did not return to Arbour-HRI after May 31, 2013. He resigned on June 19, 2013, the day his suspension ended. (Tr. VII: 952-954; Tr. VIII: 1156; Ex. R36.)

Additional Facts

74. Margaret Reid, a pharmacist at Arbour-HRI, has never seen Dr. Schwartz be disruptive, but she did not observe the incidents referenced in the Statement of Allegations. (Tr. V: 585, 602.)

75. Dr. Schwartz was never rude to Ms. Pique. (Tr. III: 387; Ex. R19.)

76. Dr. Schwartz had positive relationships with and was respected by former medical directors Aminadav Zakai, M.D. and Alia Goodheart, M.D. (Tr. VI: 856-858, 859-861; Exs. R5, R22.)

77. Some medical staff agreed with Dr. Schwartz's views about patient care and appreciated his efforts to improve patient safety. (Tr. V: 589-590, 601-602, 651-653.)

78. Mr. Moelleman was dismissed from Arbour-HRI following an incident in September 2013. Ms. McIntosh was asked to resign, apparently over the same incident. Ms. Patoulidis was moved laterally to a position with no patient contact. (Tr. I: 157; Tr. II: 309; Tr. VI: 764.)

79. The Departments of Mental Health and Public Health oversee Arbour-HRI and other such facilities. Both agencies conduct regular and unannounced inspections and may order corrective action. (Tr. I: 155, 157-158; Ex. R23.)

80. In November 2013, DMH halted admissions at Arbour-HRI when previously identified problems were not corrected. The facility was able to accept patients again on a limited basis a couple of weeks later. (Tr. I: 97; 146-147; Ex. R23.)

81. Staffing issues at Arbour-HRI were reported to state regulators. (Ex. R23.)

82. The Board did not issue subpoenas to appear at DALA directly to its witnesses who were or had been Arbour-HRI employees; instead it sent the subpoenas to an attorney representing Arbour-HRI in a lawsuit filed by Dr. Schwartz. (Ex. R25.)

83. The attorney, Janet Barringer, Esq., sent the subpoenas to the individuals with a letter offering to represent them at the administrative hearing. (Ex. 26.)

84. She represented Ms. Penhallurick, Ms. Grau, Dr. Megeed, Ms. McIntosh, Ms. Pique, and Mr. Rollins, but not Dr. Felson. (Tr. I: 148-150, 195, 198; Tr. II: 282-283, 310-311, 332; Tr. III: 382, 392, 445-446; Tr. V: 562.)

85. Ms. Barringer sat behind Board Complaint Counsel. At one point during the hearing she rose and asked to be heard, a request I denied.⁸ (Tr. I: 149-150.)

DISCUSSION

Applicable Law and Policy

The Board of Registration in Medicine alleges that Dr. Schwartz committed misconduct in the practice of medicine and engaged in conduct that undermines the public confidence in the integrity of the medical profession. The Board may discipline a physician for misconduct in the practice of medicine. 243 CMR 1.03(5)(a)(18); *Hellman v. Bd. of Reg. in Med.*, 404 Mass. 800 (1989). It may also discipline a physician who lacks good moral character and has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *Levy v. Bd. of Reg. in Med.*, 378 Mass. 519 (1979), *Raymond v. Bd. of Reg. in Med.*, 387 Mass. 708 (1982). The Board has the burden of proving its allegations by a preponderance of the evidence. *Craven v. State*

⁸ At times during testimony, it appeared that some witnesses were looking to Ms. Barringer before answering a question and that there may have been some non-verbal communication between them. (Tr. II: 232-240.) Ultimately, whether or not there was interference by Ms. Barringer, I cannot discern any effect from it on the witnesses' testimony.

Ethics Com., 390 Mass. 191, 200 (1983). *Cf. Randall v. Mass. Bd. of Reg. in Med.*, SJ-2014-0475 slip op. at 3 (June 9, 2015).

The Board may establish policies that govern physician behavior. G.L. c. 112, § 5. In 2001, the Board adopted Policy 01-01, "Disruptive Physician Behavior." (Ex. P1.) The Policy uses the same definition of disruptive behavior as does the American Medical Association (AMA) in its "Disruptive Physician Policy": "[A] style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care." The Board's Policy notes that "disruptive behavior by a physician has a deleterious effect upon the health care system and increases the risk of patient harm." Furthermore, "[b]ehaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are now recognized as detrimental to patient care." By referring to a "style of interaction" the Policy implicitly focuses on a pattern of behavior rather than isolated, unrelated instances of questionable or poor conduct.

The Policy notes that Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards regarding disruptive behavior, which health care organizations such as Arbour-HRI are required to implement, focus on rehabilitation rather than discipline, but further notes that does not relieve organizations from taking necessary corrective action or from state and federal reporting requirements. The Policy discusses the JCAHO medical staff standards issued on January 1, 2001.

In general, agency policies interpret the law that authorizes its actions, and provide guidance on the agency's administration and implementation of its authorizing statute and regulations. Unlike statutes and regulations, however, an agency's policy

statements do not have the force of law. *Mass. Gen. Hospital v. Rate Setting Comm'n*, 371 Mass. 705, 707 (1977). Nonetheless, an agency must act in a manner consistent with its policies, or risk losing the public's confidence. *See Macioci v. Comm'r of Revenue*, 386 Mass. 752 (1980).

The Policy warns that “[b]ehavior by a physician that is disruptive and compromises the quality of medical care or patient safety, could be grounds for Board discipline.” The Board alleges that Dr. Schwartz acted contrary to the Policy on several occasions.

Dr. Schwartz argues that language adopted by JCAHO in 2012, which speaks to “behaviors that undermine a culture of safety” rather than disruptive behaviors, should be applied by the Board in this case.⁹ He is mistaken. Simply put, the 2012 JCAHO language does not apply to physician discipline matters before the Board because it has not amended its 2001 Policy to adopt the 2012 JCAHO language or otherwise acted to apply the language in its proceedings. Whether the Board should adopt the JCAHO language is a policy matter that it may consider in its discretion. The Respondent has not supplied any legal basis to enforce its use through this adjudicatory proceeding.

In addition, the Board's policy is not ambiguous or vague. Its definition of “disruptive behavior” is sufficiently clear to put physicians on notice of what types of behavior are unacceptable, while accounting for the wide range of interactions that can be detrimental to patient care.

⁹ Exhibit 1 to Respondent's Response to Petitioner's Opposition to Respondent's Renewed Motion to Dismiss filed May 9, 2016; *see also* Exhibit 1 to Respondent's Renewed Motion to Dismiss and Motion for Sanctions filed April 29, 2016. I do not discuss further the language used by JCAHO because it does not apply to this matter.

Witness Credibility

Before turning to the specific incidents raised in the Statement of Allegations, I address my assessment of certain witnesses' credibility. The Board called ten witnesses on its behalf, and Dr. Schwartz called six witnesses. The witnesses had divergent observations of the same incident, which mattered some of the time, but not always. The witnesses' recall of events varied considerably. Interpersonal relationships and office dynamics came into play. Lest it appear that I did not take into consideration conflicting testimony, I offer the following to explain how certain credibility determinations affected my view of the evidence overall.

I found Mr. Rollins to be a reliable, credible witness. He probably was the most neutral witness for the Board.

Ms. Penhallurick was reliable and credible. She spoke positively about Dr. Schwartz, while also critical of his approach. Her language was neutral, and she was able to look at Dr. Schwartz's behavior from more than one point of view. (Tr. I: 145-148.)

Dr. Felson was a colleague and friend of Dr. Schwartz. I found him to be generally reliable in spite of the inconsistencies between his Board interview and his testimony. These can best be explained by a remark attributed to him: "[N]obody wants to put his license on the line." (Ex. R3.)

Ms. Reid's testimony was limited and credible. She was both critical and supportive of Dr. Schwartz.

The testimony of Ms. Patoulidis was not reliable. It was exaggerated in tone and substance. She displayed hostility toward Dr. Schwartz through her posture, glare, and tone of voice. She was eager to malign him, sometimes in lieu of answering the question

put to her. Her version of most aspects of the February meeting was exaggerated and not supported by other witnesses who were present. She had reason to be biased against Dr. Schwartz because of a prior incident, which was addressed in the 2012 Consent Order.

Similarly, Ms. Grau's dislike of Dr. Schwartz was evident through her exaggerated description of events and her tone. I specifically do not credit her testimony that she saw Dr. Schwartz yelling in the lobby on May 31, 2013. (Tr. I: 166-168.)

Dr. Gararaj's testimony was colored by his strong, negative opinion of Dr. Schwartz. Exhibits 8 and 9 are particularly self-serving. His memory lapses at the hearing were often selective. He is simply an unreliable narrator of events involving Dr. Schwartz.

I have pointed out that Dr. Gararaj refused to answer a question put to him, even after I ordered him to do so. His disrespect for the forum affected my assessment of his reliability.

I give little weight, if any, to uncorroborated, written statements of individuals who did not testify.¹⁰ Ms. Ippolito did not testify about the events of May 30, 2013. It is not clear to me whether she wrote the incident summary or Ms. Kraut, who also did not testify, wrote it. It reads as if she was interviewed. Ms. Ippolito's email was likely coached by Ms. Grau, who was copied on the message. (Ex. P10). Moreover, I do not give much weight to their conflicting statements in the summaries of their interviews prepared by the Board's representatives. (Exs. 6, 7, 9.) In addition to the fact that they were not under oath, and there was no opportunity for cross-examination, it is difficult for me to evaluate a summary of an interviewee's statements without any evidence about

¹⁰ On May 1, 2016, I denied the Board's motion to have the testimony of Ms. Ippolito, Ms. Kraut, and Mr. Moellemian taken by phone or video conferencing because there was no showing of necessity or hardship. Particularly when matters of credibility are at issue, methods other than live testimony are often inferior.

how the interviews were conducted and how the information in the summaries was elicited.

I give little weight to Mr. Moallemian's deposition testimony, which was given in the suit brought by Dr. Schwartz. (Exs. P23, 24.). Mr. Moallemian did not address the events in the Statement of Allegations. To the extent he spoke about Dr. Schwartz's behavior, he was vague, general, and not helpful. It was unclear whether he was speaking from personal knowledge. *See e.g.*, Ex. P24 at 36.

For the reasons stated above, I give little weight to the Board's summaries of its interviews with Valerie Massiah, switchboard receptionist, and John Peterson, director of facilities, who interacted with Dr. Schwartz on May 31, 2013. (Exs. R10, 18).

Dr. Schwartz was not represented by counsel. Acting as one's representative and witness can be challenging and stressful. Dr. Schwartz's demeanor throughout the hearing was appropriate for the most part. Despite what appeared to be Complaint Counsel's attempts to provoke him, Dr. Schwartz did not exhibit any "out of control" behavior. While he raised his voice on occasion and expressed annoyance or frustration sometimes over legal procedure (as do most *pro se* litigants), I found him to be respectful of the forum and accepting of limits and of rulings not in his favor.

Particularly on cross examination, Dr. Schwartz was impatient, evasive or unresponsive at times. He occasionally clung to a particular response to the point of intransigence. I did not always fully credit his version of events when his testimony was exaggerated or evasive and another credible witness offered a different version.

Whistleblower Defense

Dr. Schwartz argued that his speech and actions were protected because he was a whistleblower. G.L. c. 149, § 187 provides a cause of action to health care providers, including physicians, who are retaliated against for disclosing problems within health care facilities. It does not provide a defense to physicians in administrative actions brought by the Board.

Prior Discipline; Matters outside the Statement of Allegations

Dr. Schwartz signed a Consent Order with the Board in 2011 that concerned an incident with Ms. Patoulidis. (Ex. P2.) The Consent Order imposed no ongoing obligations on Dr. Schwartz.

In its closing brief the Board “respectfully requested” that I “outline the Respondent’s failure to address his behavior.” I assume the Board is referring to its view of Dr. Schwartz’s actions or inactions following the 2011 Consent Order. I respectfully decline.

No allegation addresses such a failure on the part of Dr. Schwartz. The Board does not direct me to a legal provision such a failure would violate. I do not consider findings of fact on such a failure to be “necessary to the decision, ...” G.L. c. 30A, § 11(8).

Physician Profile

Dr. Schwartz had an ongoing dispute with the Board about his Physician Profile, a public document. The Board’s Data Repository unit maintains a Profile on each licensed physician under G.L. c. 112, § 5. Such disputes, however, cannot be resolved in an adjudicatory hearing on a disciplinary matter. While a factual thread connects the Profile

dispute and the Statement of Allegations, they are separate matters with different avenues available to challenge the Board's actions.¹¹

The Physician Profile retrieved on April 7, 2014 (Ex. R36) shows that the correction sought by Dr. Schwartz was made. The reference to revocation as a result of Arbour's complaint was deleted and the Profile now reflects that his suspension ended June 19, 2013.

Grounds for Discipline

On February 28, 2013, Dr. Schwartz engaged in disruptive behavior when he referred to Ms. MacIntosh as a bitch. "Behavio[r] such as foul language...[is] detrimental to patient care." (Policy.) Cursing at a colleague is unacceptable in a professional setting. He further engaged in disruptive behavior when he told Ms. Grau he could buy and sell her a million times. "Behavio[r] such as...offensive comments...[is] detrimental to patient care." (Policy.) Referring to buying and selling another human being is highly offensive and unacceptable in any setting. Dr. Schwartz's explanation here is no excuse. To a lesser degree, Dr. Schwartz was disruptive when he interrupted the February meeting, albeit as it was ending, and spoke in a loud, agitated manner. He was not able to calm himself until he had spoken with Mr. Rollins for some time. Dr. Schwartz was raising an important issue about patient information not being available to clinicians because of the way in which Arbour-HRI's management was addressing the computer problem. While his intention was to protect patients from errors by assuring that staff had necessary medical information, Dr. Schwartz's apparent frustration affected his ability to communicate his concerns to his colleagues. The way Dr. Schwartz attempted to address the matter was disruptive.

¹¹ I allowed Dr. Schwartz great leeway in his attempt to establish a triable issue.

Incidents like these may not directly affect patient care, yet they take their toll eventually. It is difficult to work well with someone when the thought uppermost in your mind is "he called me a bitch this morning."

Dr. Schwartz was not disruptive during his encounter with Dr. Gajaraj on May 9, 2013 when he complained about the failure of the psychiatrist on call the previous evening to do a complete medical work up of a new patient. Dr. Schwartz had a legitimate complaint about medical care provided the previous evening, which he tried to take up with the medical director. Although Dr. Schwartz had raised this issue before, Dr. Gajaraj had failed to take any action in the past. Moreover, Dr. Gajaraj and Dr. Schwartz did not get along with each other. While one's dislike for the other no doubt affected how both viewed and remembered the incident, I found Dr. Gajaraj to be a less than reliable narrator in general, as discussed above. He tried to ignore Dr. Schwartz, which apparently included not take seriously any matter Dr. Schwartz raised. Dr. Schwartz's behavior did not rise to the level of being disruptive as the Policy describes.¹²

On May 30, 2013, Dr. Schwartz engaged in disruptive behavior when he spoke curtly to staff who asked to use the treatment room he was in for a johnny search, and again, shortly thereafter, when he and Dr. Gajaraj were arguing and staff told them the same patient was nearby and could overhear them. All staff involved had legitimate medical reasons to use the treatment room. Dr. Schwartz, who was just finishing his assessment notes and orders, could have simply stated he would be done in a few minutes and asked them to wait. Or he could have completed his work at the nearby nurse's station. Instead he said no, without explanation. This was rude and disrespectful to other

¹² I find little difference in Dr. Schwartz's and Dr. Gajaraj's behavior during this incident. Dr. Gajaraj was not disciplined by the Board, however. I recognize the Board's considerable discretion in the exercise of its authority to sanction. Nonetheless, the Board's decision affects how I view the facts here.

members of the care team and to the patient with them. That the space was Dr. Schwartz's only "office" does not give him absolute priority or excuse his rude behavior. In this instance, Dr. Schwartz expected other staff to defer to him as the doctor. This attitude, at best, is an old-school notion at odds with current medical practice, as illustrated by the Policy's emphasis on teamwork. "[Physicians] must consider that 'the importance of respect among all health care professionals as a means of ensuring good patient care is at the very foundation of the ethics advocated by the AMA.'" (Policy at 3.)

Dr. Schwartz and Dr. Gajaraj were arguing in an open area and, when told a patient could overhear them, Dr. Schwartz said: "I don't care." His dismissive attitude is a serious breach of professionalism and is detrimental to patient care, whether the patient appeared upset or not at the time. It also is disrespectful to colleagues who were simply trying to do their job.

On May 31, 2013, Dr. Schwartz did not engage in disruptive behavior when he referred to Mr. Moallemian as an asshole. Cursing at a colleague is unprofessional. Mr. Moallemian, however, had just suspended Dr. Schwartz, understandably an upsetting situation for him. The two men did not get along with each other. I recognize that the Policy considers behavior such as foul language to be detrimental to patient care. This was a personnel matter, however, that did not implicate or interfere with patient care. Not every interaction between a physician and an administrator falls under the Board's Policy.¹³

¹³ In this decision, I accept the Board's argument that its Policy can extend to a physician's interactions with individuals who are part of hospital administration. The same individuals often have administrative and patient care responsibilities. Nonetheless, the Policy's reach is not so broad as to capture every interaction between a doctor and other employees.

The Board's evidence on whether their dispute spilled into the hospital's public is simply insufficient. The individuals who purportedly observed or interacted with Dr. Schwartz in the public areas did not testify.

The Board did not prove that Dr. Schwartz was suspended and stopped working in September 2013. As the Board acknowledged in its closing brief, Dr. Schwartz was suspended on May 31, 2013, the last day he saw patients at Arbour-HRI.

Misconduct

Recognizing that actions at odds with a Board Policy are insufficient grounds to impose discipline, the Board charges that Dr. Schwartz's failure to abide by the Policy constitutes misconduct in the practice of medicine, 243 CMR 1.03(5)(a)(18).

In *Hellman*, 404 Mass. at 804, the Supreme Judicial Court defined misconduct, in general, as:

"improper conduct or wrong behavior... [and it] implies that the conduct complained of was willed and intentional. It is more than that conduct which comes about by reason of error of judgment or lack of diligence. It involves intentional wrongdoing or lack of concern for one's conduct. Whether or not an act constitutes misconduct must be determined from the facts surrounding the act, the nature of the act, and the intention of the actor.

Thus, in order for disruptive behavior to constitute misconduct, it must involve "intentional wrongdoing or lack of concern for one's conduct," and one must examine "the intention of the actor." *Id.* In *Bd. of Reg. in Med. v. Bock*, RM-14-16 (Div. Admin. Law App., Jul. 16, 2018, adopted Nov. 8, 2018) the magistrate found that Dr. Bock's interactions with patients were not so disruptive as to be detrimental to patient care in part because his intent was not to insult or demean them, but to treat their addiction and other health issues.

Dr. Schwartz committed misconduct in violation of 243 CMR 1.03(5)(a)(18) when he engaged in several instances of disruptive behavior with Arbour-HRI medical and administrative staff. On one occasion, a patient was present. Repetitive instances of disruptive behavior constitute misconduct. *Bd. of Reg. in Med. v. Salah Reyad, M.D.*, Case No. 2013-048, Consent Order (September 25, 2013) (repeated instances of disruptive behavior spanning six years are misconduct and warrant reprimand).

In *Bd. of Reg. in Med. v. Peter J. Mulhern, M.D.*, RM-05-36, RM-05-1237, Recommended Final Decision *aff'd* by Final Decision and Order (Sept. 5, 2007), Dr. Mulhern was found to have engaged in a pattern of misconduct including verbal confrontations, throwing a sandbag and injuring a co-worker's foot, threatening to punch another doctor, yelling, and profanity.

Conduct Undermining Public Confidence

The Board further charges that Dr. Schwartz lacks good moral character and has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *Levy*, 378 Mass. 519. The Board is charged not only with protecting public health, welfare, and safety, but also with protecting "the vast majority of physicians in the community who do possess 'the highest degree of integrity.'" *Id.* at 528, *Raymond v. Bd. of Reg. in Med.*, 387 Mass. 708, 713 (1982) (Board has authority to protect the image of the profession).

The Board has also determined that a physician who discharges his frustration with disruptive behavior toward colleagues and staff undermines public confidence in the integrity of the medical profession. *Bd. of Reg. in Med. v. Matthew Philips, M.D.*, Case No. 2013-040, Final Decision and Order (November 19, 2014) (based upon the parties'

stipulation of facts and conclusions of law, physician admonished for instances of disruptive behavior with patient, family member, and colleague over a single day.)

Dr. Schwartz's disruptive behavior toward Ms. McIntosh and Ms. Grau on February 28, 2013 stemmed from his frustration over missing patient information. His behavior on May 30, 2013, when a patient was present, showed poor judgment at best and undermines public confidence in the integrity of the medical profession.

Mitigation

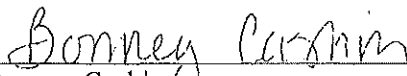
Dr. Schwartz is without question an excellent clinician; a point conceded even by those who disliked him. He sincerely believes in the paramount importance of patient safety. In his view, Arbour-HRI's administration did not hold to the same standard.

Arbour-HRI was a troubled workplace on many levels. Dr. Schwartz's behavior, however, was more a symptom of larger problems than the cause. This in no way excuses his behavior, but it does mean it should be understood in the larger context in which it occurred.

Conclusion

For the reasons stated above, I conclude that Dr. Schwartz is subject to discipline by the Board. I urge the Board to consider mitigating factors and the period of time that has passed since the record closed.

DIVISION OF ADMINISTRATIVE LAW APPEALS



Bonney Cashin
Administrative Magistrate

DATED: December 29, 2020