RUSKIN MOSCOU FALTISCHEK P.C.
Counselors at Law

# To Interview or Not to Interview

# That is the Question

By: Gregory J. Naclerio*[*]

In the course of responding to your daily glut of e-mail, your phone rings. At the other end is a long time friend and colleague who asks: "Hey, you practice health law, one of my clients – an ER doctor – got a letter from something called OPMC asking him to go to their office for an interview. Should I let him go? What could be better," your friend muses, "than to let the Doctor tell his side of the story…" While a simple question generally requires a simple answer, your colleague's inquiry should trigger an entire analysis which will lead to counsel's recommendation to the doctor to go to the interview or not.

## THE BASICS: UNDERSTANIDNG THE PAYING FIELD

The Office of Professional Medical Conduct (OPMC) is the part of the New York State Department of Health which has the responsibility of investigating and if appropriate, prosecuting physicians for acts of professional misconduct. While OPMC has the power to commence *de novo* investigations, generally, it will respond to complaints or news stories alleging physician misconduct. Every complaint received by OPMC must be

investigated.[1] Complaints come from many sources such as irate patients or their family members, anonymous individuals, as well as other physicians or hospital administrators which have an affirmative obligation to report suspected physician misconduct.[2] Recently, OPMC is believed to be reviewing medical malpractice settlements as reported to the National Practitioner Data Bank[3] to identify Physicians who have committed acts of negligence. All these "complaints" must be reviewed by OPMC Investigators (the "Investigator") who makes the initial decision to close a complaint after a desk review or to commence further investigation. The additional investigation may include a personal interview with the complainant and a request to the physician (hereinafter, the "Physician") for the patient's chart. The Investigator's request for a patient chart is usually the first way the Physician becomes aware of an OPMC investigation. Once the preliminary investigation is conducted, the Investigator can determine that no credible evidence of professional misconduct exists and will request that the case be closed. On the other hand if the Investigator believes additional inquiry is needed, he can extend to the Physician the opportunity to appear at the OPMC offices for an interview (the "Interview") with the Investigator and the OPMC Medical Coordinator (the "M.C.").[4]

The second thing you need to know about the OPMC "playing field" is what type of conduct incurs the wrath of OPMC. Happily, this one is easy; all you need to do is become familiar of what constitutes "professional misconduct." A review of Ed Law §6530, 6531 and New York State Health Department Regulations 8 NYCRR §29.1, 29.2 and 29.4 will explain in detail what actions constitutes professional misconduct.[5] The analysis is much

like reviewing the Penal Law to ascertain what type of action subjects a citizen to criminal prosecution. Thirdly, you must learn the procedure, burden of proof and rules of evidence that apply to OPMC actions from the filing of charges up to your remedies on appeal.[6] This must be learned so as to put all your decisions in context. You cannot play a game of chess and develop the strategy you need to win without knowing the moves each piece makes. The same is true with an OPMC case. You need to know all the options available to you in order to make an informed decision. Lastly, you need to know the sanctions OPMC can impose upon your client if he pleads to or is convicted of professional misconduct. These penalties range from a non-public Administrative Warning to a public Censure and Reprimand (C&R), up to a very public revocation of your client's license to practice medicine.[7]

## THE BASICS: GETTING THE PHYSICIAN'S ATTENTION

Generally, Physicians pay minimal attention to the *business* of the practice of medicine. Anything other than the actual practice of medicine is deemed something a Physician doesn't have time to deal with. For you to succeed in the defense of a potential OPMC case you need to get the Physician's full attention.

Someone once said that the only way to get a donkey's attention is to "…whop him upside the head with a 2 x 4." To a certain degree the same is true with your Physician-client who is too busy "saving lives" to bother herself with the OPMC. The 2 x 4 that you have is what can happen to her

in the event of an adverse OPMC finding. Even if you attempt to utilize this tactic, the Physician may retort: "Counselor, even if OPMC proves their case they are not going to revoke my license. Additionally, one of my former residents, now in his second year of law school, said I should plead 'No Contest to negligence on more than one occasion' so I formally admit nothing." The Physician is probably correct that she would not lose her license but this does not end the discussion. You must advise her of the consequences of her decision by using a 2 x 4 something like the following:

> Doc, you're probably right that you won't lose your license. We could decline to go to the Interview and if formal charges are filed we could probably negotiate a stayed suspension of three years in a 'No Contest' disposition. If you don't want to put up a defense, the entire matter can be resolved in 3-4 months and you won't have to waste your precious time meeting with me to prepare for the Interview, reviewing the patient's chart in detail or taking time off to go to the Interview. You will not only save time but legal fees as well.
>
> Come to think of it Doc, the strategy you and your resident/law student devised could really give you some extra time off. See, Doc, the quick fix you suggest will surely

terminate the OPMC matter, but it will also leave you with some not so good *parting gifts*.

For example: (a) your name gets placed on the OPMC website[8] showing the charge to which you pled No Contest.

(b) you also get a cross link back to the OPMC website when one of your patients or future patients wants to check you out at the *Health Department's Physician Profile*.[9]

(c) you then get the honor of having an entry under your name in the National Practitioner Data Bank.[10]

(d) since the information about your No Contest is public information, you may even make your town newspaper. That should be real good for business.

(e) Managed Care Companies also check the OPMC website. You probably don't care because managed care companies "don't pay enough anyway" but most carriers can dis-enroll you from their Panel with 30 day's notice for "any reason." Being on the OPMC website could well be "any reason."

(f) Medicare also reviews the

disciplinary proceedings handed down by the State and may decide to commence their own inquiry.

So, when you figure that (i) the publicity could cause current patients to seek another PCP and new patients are not going to see a doctor who pled No Contest to negligence on more than one occasion; (ii) 2 or 3 of your six (6) managed care plans may decide to kick a negligent provider out of their plan; and (iii) Medicare could start an inquiry into your quality of care, the total effect of your colleague/law student's idea just to roll over on a No Contest disposition could probably give you enough extra time to lower your handicap by 5 or 6 strokes. That's until you get sued for malpractice by the patient you involved in your No Contest plea.

While admittedly the above monologue is fictitious, the points it makes are quite real. You need to impress upon your doctor-client that this is serious stuff. While the doctor may feel the claims against her are "unjustified," some trained OPMC investigator feels otherwise or he would have closed the case administratively. To the Investigator there exists a valid claim of professional misconduct. Hence, the ball is in the Physician's

court.

**PRACTICE TIP**:

Once you have the Physician's attention, you need to meet with her to start preparing a defense. Some guidelines are as follows:

a) The Physician must come to your office for the initial meeting in order to get her complete attention. If you go to the Physician's office even after patient hours, she will get constant interruptions by staff or patient's telephone calls. You need a location where the Physician can give her OPMC problem full attention and that place is your office.

b) Show the Physician you care about her and her problem by giving her your undivided attention. You don't want to go to a doctor's office where the doctor rushes into the exam room, puts a stethoscope to your chest over your shirt, declares you have bronchitis and then bolts out of the room to see her next patient. Handling an OPMC matter is serious as the livelihood of your client is at stake even if her license is not revoked.

c) If you never handled an OPMC case, follow the course doctors take to learn a new procedure. Bring a seasoned OPMC practitioner into the case as your "Special Counsel." Even if you have to waive

your fee, you will be able to learn the procedure much like a resident learns from an attending surgeon.

d) Doctors, perhaps more than other clients, are concerned about legal fees. (In my judgment, it's not like they can't afford your fees but that they don't like lawyers thanks to our medical malpractice brethren). As part of your caring for your clients inquire if the Physician has purchased professional misconduct defense insurance as part of her general medical malpractice policy. Both MLMIC and PRI offer this type of extra coverage for a modest fee. Tell the Physician to check her policy because she may not even recall if she is covered. If the Physician is covered by MLMIC have her contact the carrier to advise them she has retained you to defend the case. Then, follow it up with a letter to MLMIC. MLMIC provides up to $25,000 of defense costs in an OPMC case. If the Physician has a PRI policy, have the Physician contact PRI and request that you be appointed as the Physician's attorney of choice. You will have to accept the PRI fee schedule in that case (No, you cannot charge the Physician the difference between the PRI fee schedule and your normal hourly rate).

e) If you are requested by OPMC to provide one or more of the Physician's patient charts, you will also be asked by the Department to "certify" the records submitted are true and accurate copies of the original chart. There exists no legal authority for this request by OPMC and following the practice of the late T. Lawrence Tabak –

the Dean of OPMC trial attorneys – I decline to do so. This then forces OPMC, should the case go to a Hearing, to lay the proper foundation to have the records admitted. No sense making their work any easier… especially if you get nothing in return.

**THE BASICS: YOUR INVESTIGATION**:

Where you start clearly depends on the allegation of professional misconduct; but it always is the same: you start at the beginning collecting facts and deciding upon your defense strategy. The OPMC interview letter is *supposed* to give you the parameters of the OPMC investigation. If the letter merely recites that the OPMC investigation is into the "care and treatment of patient Santa Claus" that is not sufficient!

**PRACTICE TIP**:

If you get a "care and treatment" letter, call the Investigator and remind him that it is OPMC policy to spell out for you, in general terms, exactly what they are investigating and what they wish to discuss at the Interview. If the Investigator refuses, you have the option – which you must take – of speaking to the OPMC Regional Attorney to obtain that information.

Once you have the general scope of the investigation, you need to

obtain the complainant's entire patient chart.

**PRACTICE TIP**:

You should ask the Physician to introduce you to her office manager and she should be directed to get you three legible copies of the complainant's chart. One becomes your "virgin" office file copy; the second is your working copy; the third will be used by your expert if appropriate for the case. All copies should be Bates Stamped.

**PRACTICE TIP**:

The Physician and her staff must be *ordered* not to make any additions, deletions or omissions from the original patient chart. That includes signing off on notes today that should have been signed off when the note was made. Nothing puts a Physician in worse position before OPMC than being accused of "falsifying" the original chart. I would much rather have a Physician who is "sloppy" than a Physician who is deemed "devious."

**PRACTICE TIP**:

In the event the OPMC complaint alleges professional misconduct while the patient was in a hospital, the Physician should be directed to obtain a copy of her hospital Credentialing File. If an allegation of professional misconduct is made to a hospital, the hospital must conduct its own quality assurance investigation. That investigation may result in the hospital filing an NYPORT (New York Patient Occurrence and Tracking) form with the Department of Health.[11] The hospital Administration will generally send any patient complaints to the department of the hospital in which the Physician is credentialed. That department will then conduct a peer review and determine if the Physician "met the standard of care" or failed to do so. The department's review is then sent to the hospital's Risk Manager and is reviewed by the hospital's Quality Improvement Committee, a sub committee of the Board of Trustees. A copy of the ultimate decision based upon this review is placed in the Physician's Credentialing File. If the hospital's review has determined the Physician's treatment of the complainant has "met the standard of the case" that is an important piece of evidence in your favor.

Your investigation commences with an in-depth review of the complainant's chart along with the correlation of the allegations against the Physician to the chart. Let the Physician take you through the chart and you

should be asking probing questions as you go. The probing questions will really depend on your experience with OPMC cases and your knowledge of medicine. While you don't have to be a pre-med major to handle an OPMC case, you can and should learn the relevant specific medical procedures and terms by talking to your client and doing research on the Internet.

**PRACTICE TIP**:

Don't rely solely on the medicine as relayed to you by your client. The client interview is a prime source for you to learn about the procedures being questioned by OPMC. You must become facile with the area of medicine involving your client's case. Depending on the complexity of the case you may want to send a copy of the chart out to a Physician who is a specialist in the given area for an opinion as to the strengths and weaknesses of your case. You should also run your theory of defense by your expert for her opinion and guidance.

If the allegations against your client do not implicate the practice of medicine, such as in a sexual boundary case, you need to conduct your investigation just as you would in defending a criminal case. You commence by identifying potential witnesses, interviewing them and getting statements. Depending on the facts you may want to retain a private

investigator for these purposes.

**WHY YOU SHOULD GO TO THE INTERVIEW**:

The purpose of the Interview is to permit the Physician to answer the allegations made by the complainant by providing her side of the story and facts to support her position that no professional misconduct occurred. The defense bar sought this opportunity to have the doctor's position on the record prior to the filing of formal charges for many years and ultimately succeeded. Prior to the change in the statute, the doctor would first be given notice of OPMC action *after* formal charges were filed. Now, you have the opportunity to avoid the filing of formal charges and the angst such action will cause.

Thus, in my judgment, the Interview is a time for the Physician and her counsel to be proactive. You are *not* at the Interview to be interrogated. You are there to state your case and show OPMC that charges are not warranted and the matter should be closed. The fact that OPMC *invites* you to an interview, gives the impression they are in control. It should be better stated that *you* are exercising your right to provide needed information to OPMC. While theoretically you are then in control of the Interview, it won't seem that way. However, you need to be aware of your statutory right to present your position and not be interrogated by an OPMC representative. Thus, you need to control the meeting indirectly. You do that through an in-depth preparation of the Physician who will present her

case and present, if appropriate, medical literature to support her position. As counsel you also must make sure that your client makes all her key points and, if need be, correct any "facts" relied upon by OPMC. Thus, if you have a position you want to make known to OPMC that can pass your "smell test" and if your client makes a good presentation, as a caring, knowledgeable doctor, an Interview may be in order.

**PRACTICE TIP**:

Place all the key points you want the Physician to make on an index card and check them off when made. If additional comments on a point are required, make a note to do so after the Physician speaks.

**PRACTICE TIP**:

The Interview is a peer review "discussion." You don't play a passive role like a defense attorney on CSI. You can within reason, be pro-active by re-enforcing your client's key pieces of evidence and guiding the discussion to your strong points.

## WHY YOU SHOULD NOT GO TO THE INTERVIEW

Generally, you can always find some important facts you want to bring to OPMC's consideration to either close the case against your client or

to at least mitigate the charges that will be filed. Nevertheless, there are times when the request for an Interview should be declined. An example of a case in which a doctor should *not* go to an Interview involved a doctor who was Chief of Psychiatry at a large teaching hospital. The doctor came to OPMC's attention when the *New York Post* carried his story and dubbed him "T*he Sex Slave Shrink*." The story went on to report how the doctor had become infatuated with his young secretary and written her prescriptions for Vicodin. The secretary became "hooked" on Vicodin and when she requested additional prescriptions the doctor would demand sexual favors in return for a Vicodin script. When the secretary's family finally got her to rehab, she told the story that the *Post* deemed to be worthy of page one. When OPMC requested the doctor provide the secretary's patient chart there was nothing to give. The Psychiatrist was in a Catch 22 situation. He should not be writing prescriptions (especially narcotics) if the secretary was not his patient (See, Penal Law §220.65) and if she was a patient, where was her chart? (8 NYCRR 29.2(a) (3)). Additionally, the facts uncovered in counsel's investigation supported the allegations against the doctor. Clearly, the doctor was checkmated even before he got to the sexual impropriety issue. Against the advice of Counsel the Psychiatrist *demanded* to meet with OPMC with or without his lawyer. The defense proffered by this doctor was simple but totally ineffective:

> We all write scripts for our family, co-workers and friends without performing an exam or keeping a patient chart.

Predictably, the discussion between the Psychiatrist and the MC immediately degenerated into a yelling match, which generated significant heat and insignificant light. The Psychiatrist's defense did not pass the smell test and he should not have gone to the Interview. Not only did OPMC file formal charges but the fact that the Psychiatrist appeared at the Interview with a laughable defense and with a complete lack of regard for the traditional rules of medicine led OPMC to conclude the doctor showed "no remorse" for his improper behavior. His performance haunted the Psychiatrist throughout the settlement negotiation of the charges filed against him.

## PREPARATION FOR THE INTERVIEW

Once you have made the decision the Physician should go to the Interview, you just don't waltz your client into OPMC to tell her side of the story without being adequately prepared. Remember the 5 P's:

*Prior Planning Prevents Poor Performance*.

First, you must know your adversary. The Investigator has spent considerable time reviewing the complainant's allegations, which may have included a face-to-face meeting with complainant and the interview of any applicable witnesses. As a result the Investigator has a working hypothesis which he has passed on to the MC. Generally, the MC is a retired or semi-retired Physician with broad experience including some academic responsibilities such as serving as the chair of a residency program. Also,

the MC will have the benefit of 20/20 hindsight in his questioning/discussion of the Physician. The MC will have also gone through the submitted patient or patients' charts and will know the salient points of the allegation cold. The MC will be prepared and so should your client. If you are able to ascertain the name of the MC it will inure to your client's benefit to obtain information on the MC by checking the State Medical Society Directory and performing a Google of the MC to obtain his/her background.

Second, your client must be prepared and prepared well. The Physician must know the patient's chart as well as she knows her own phone number. The Physician must be prepared by you (taking the role of the MC) by going through the chart's important points. Tell the Physician she must equate the Interview with taking the oral Boards for her subspecialty. You also need to ask the Physician the "hard questions" you expect the MC to ask. You need to assess and perhaps improve the Physician's responses to the hard questions. The Physician should have also reviewed any applicable medical literature on the issue being discussed and have it prepared for your review. The goal is to show the MC and Investigator your client is a competent, caring, hard-working Physician doing the best she can under the circumstances presented in the case under review.

Third, your client must be prepared to "teach" the Investigator and MC about her subspecialty. Generally, OPMC tries to retain an MC who is Board Certified in the same specialty as the Physician, however, often this does not occur. Therefore, the Physician must "teach" the elements of a

procedure under review clearly but without appearing condescending.

Fourth, in an appropriate case, it may not be wrong for the Physician to state: "I made a mistake that I now realize occurred after I reviewed the patient's chart in-depth. However, when I made the decision in 'the heat of battle,' I believed I made the correct decision."

Fifth, prepare the client as you would any client for a deposition. Specifically, you should prepare your client to: (i) listen to the question; (ii) understand the question; (iii) answer the question, and (iv) don't volunteer information. You also must re-enforce in the doctor's mind that although she is not under oath, she MUST tell the truth, the whole truth and nothing but the truth. Being labeled as a "liar" by OPMC will hurt the client down the road when the case is settled or goes to a Hearing.

Sixth, you need to control your client. Put yourself in the shoes of the Physician. Some one you worked really hard for has made a complaint about your competence to a State regulator and you believe you did nothing wrong. Just think about one of your clients making a complaint against you to the Grievance Committee. You would be scared, angry and consider the whole thing a waste of time. Those similar thoughts are going through the Physician's head as well. Thus, while understandable, your client will do more harm than good if she goes to the Interview with an "attitude." Let the Physician rail against you about the "injustices of the system" and "the ungrateful patient." Get all the "poor me" stuff out of the way and then get the Physician to focus.

Seventh, have medical literature addressing the subject reviewed by the Physician and compare her actions with those of her peers. You should also challenge the Physician with the findings of your expert and formulate appropriate responses.

Just like in football, the practices should be hard enough so as to make Sunday's game seem like practice.

**AT THE INTERIVEW**:

If the subject matter of the Interview will be the medical care your client rendered, the MC will be the lead questioner. As most MC's will be academic types who "go by the book," your client must know this and pay close attention to the questions posed. While remaining professional, the Physician must be ready to clearly and succinctly defend her position. You should also have available support for your client's position (medical literature) in the event you need to produce the document. Generally, no "trick questions" will be asked and the format will be one of a peer review setting. In the event the case involves non-medical issues, the Interview may be conducted by the Investigator alone. Investigators tend to be more aggressive than the MC and it will be part of your job to rein in an aggressive Investigator. The Investigator will be seeking to confirm the facts he has already learned from other sources through the Physician. Your task is to get the facts favorable to your client before the Investigator. While being respectful the Physician should be ready to highlight the facts that supports her position in a strong and confident voice.

In the event the Interview goes into areas you are not prepared to address at that time, you can so state and agree to either a follow up Interview or request to submit additional information, in writing, after the Interview ends. You should never get into the position of having your client answer questions she has not been prepared to answer. As at trial you should be reasonably certain of the answer your client will give before she answers the question. Remember, this is your opportunity to provide favorable information to OPMC… you need to stay in control of the Interview.

**PRACTICE TIP**:

Don't be afraid to have your client state: "If I knew X when I did Y, I would agree Z would have been the better course to follow." Don't get boxed in by taking a position that is patently ridiculous. If at the end of the Interview you believe additional information should be provided to OPMC, ask that the Investigator's final report be held open for a short time so you can provide additional information. Your job is to have your client bring the Investigator/MC to your side of the argument just as if you were in front of a jury. While the MC may state that he/she just writes up a report of the Interview, the MC is acting as a filter to have meritless cases closed out while having charges with merit go to the Investigative Committee for their review. A negative MC recommendation will almost assure charges will be filed. In short, your best course in getting the case against the Physician closed is to convince the MC of the correctness of your position and that your client is a competent practitioner. Part of doing so is to make sure all

the points you have on your check list have been made and made well.

**PRACTICE TIP**:

At the start of the Interview you will be asked for (or in any event you should provide) the Physician's C.V. Most doctors in private practice do not have a current C.V. Therefore, you should have the Physician prepare a C.V. for your review which should be as detailed as possible (this is not a time for modesty). The C.V. should be edited by you and retyped in the traditional form for presentation at the Interview.

**PRACTICE TIP**:

You should have a paralegal come with you to the Interview for the purpose of taking notes. The Investigator will be taking copious notes while the MC asks your client questions and your client makes her statements in support of her position. The Investigator's report of the Interview will become part of the "official record" should the case proceed to a Hearing. You need to make sure the official report is correct, so you will need a record of the Interview for yourself. As it is extremely difficult to take notes, listen to the questions, and make sure your client responds fully and accurately, another pair of hands is a must. The Interview is an extremely critical part of the OPMC process. You need to give it your undivided attention. You

should also be aware that while not in writing, OPMC policy permits you to bring in a stenographer to record the Interview at your expense with the understanding you will provide a copy of the record to OPMC.

**PRACTICE TIP**:

Know when to quit. If you feel you made all the points you wanted and made them well "get out of Dodge." Towards the end of the Interview, the Physician may start feeling comfortable with the MC and when the MC concludes the Interview, the Physician may seek to get into some "off the record" discussions with the MC. The only problem is nothing is "off the record." Caution your client of that fact and as the old adage teaches: Once you made the sale…leave."

**CONCLUSION**:

When you represent a doctor before OPMC you literally have that Physician's license and livelihood in your hands. You must be prepared to represent your client vigorously. Hopefully, this short overview will assist you in meeting your responsibility.

---

[*] Gregory J. Naclerio is a partner at Ruskin Moscou Faltischek, where he is Chair of the Health Law Regulatory Department and co-chair of the White Collar Crime & Investigations Group. He is also a member of the Corporate Governance Practice Group

[1] PHL§230 (10) (a).

[2] PHL§230 (11) (a)

[3] 45 CFR Part 60, See also, National Practitioner Data Bank Guidebook.

[4] PHL§230 (10) (a) (iii).

[5] See, Appendix A.

[6] See, generally, PHL§230.

[7] See, PHL§ 230 (10) (m) (iii) and 230-a.

[8] www.health.state.ny.us/nysdoh/opmc/main.htm.

[9] www.nydoctorprofile.com/welcome.jsp.

[10] See, FN 3, *Supra*.

[11] See list of Required NYPORTS, Appendix B.