STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 · Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

Public

June 9, 2006

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Martin Kosich, M.D.
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NYS Department of Health
ESP-Corning Tower-Room 2509
Albany, New York 12237-0032

RE: In the Matter of Martin Kosich, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 06-30) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Sean D. O'Brien

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of

Martin Kosich, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 06-30

Before ARB Members Grossman, Lynch, Pellman, Wagle and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Kevin C. Roe, Esq.**
For the Respondent: **Madeline Sheila Galvin, Esq.**

After a hearing below, a BPMC Committee determined that the Respondent practiced with negligence on more than one occasion and incompetence on more than occasion in treating six patients. The Committee voted to revoke the Respondent's License to practice medicine in New York State (License). In this proceeding pursuant to N.Y. Pub. Health Law (PHL) § 230-c (4)(a)(McKinney 2006), both parties ask the ARB to nullify or modify that Determination. After reviewing the record and the parties' submissions, the ARB votes to affirm the Committee Determination that the Respondent engaged in professional misconduct, to modify the Determination in part and to affirm the Committee's Determination to revoke the Respondent's License.

Committee Determination on the Charges

The charges before the Committee alleged that the Respondent violated N. Y. Educ. Law (EL) §§ 6530(3-6) (McKinney Supp. 2006) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,

- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion, and,
- practicing medicine with gross incompetence.

The charges related to the care that the Respondent provided to six patients, A-E and G. The record refers to the Patients by initials to protect patient privacy. The Respondent denied the charges and the matter proceeded to hearing.

The Committee's Determination following the hearing sustained allegations that the Respondent practiced with negligence and incompetence on more than one occasion in treating Patients A-E and Patient G. The Committee dismissed all charges that the Respondent practiced with gross negligence and gross incompetence.

The Committee determined that the Respondent failed to perform adequate histories and physicals on the Patients and failed to inquire into other treatment the Patients received. The Respondent treated four of the six Patients at issue with methadone. The Committee found that the Respondent failed to manage methadone treatment in a professionally acceptable manner. The Committee found further that the Respondent provided the methadone patients haphazard treatment, with no plan or regimen, no patient accountability and no physician oversight. As to the treatment for Patient A, the Committee found that the Respondent diagnosed the Patient with hypertension, but failed to ascertain the underlying etiology of the condition and the extent to which the condition affected the Patient's health. The Committee also found that the Respondent hindered the treatment process by treating the hypertension with a number of different medications simultaneously. The Committee found that, in treating hypertension, a physician should begin treatment with a drug from a particular class, continue with the drug until it shows as ineffective or not tolerated and then try a drug from a different class. The Respondent failed to do that for Patient A. Also in treating Patient A, the Committee found that the Respondent failed to address an elevated pulse rate for the Patient and failed to conduct an EKG after diagnosing atrial fibrillation. The Committee also found that an MRI on Patient A showed a bone chip pressing against the Patient's spine, but that the Respondent failed to act upon that information by referring the Patient to an orthopedic surgeon. The Committee also found that the Respondent

failed to meet accepted medical standards in the prescribing practices with respect to Patient A. The Respondent began by prescribing two opiate analgesics with the potential for overdosing, then increased the potential for harm by adding Darvocet, then added to the harmful mix by adding an additional opiate, with acetaminophen. The Committee also found that the Respondent failed to monitor the Patient's use of the potentially harmful combination. As to the treatment for Patient B, the Committee found that the Respondent failed to make a referral when the Patient presented with an enlarged lymph node. The Committee found such omission failed to comply with accepted practice standards due to the Patient's status as HIV Positive. As to the care for Patient E, the Committee found that the Respondent failed to evaluate and treat the Patient appropriately for arthritis. The Committee found that the Respondent started treatment inappropriately with a narcotic agent rather than a non-steroidal, anti-inflammatory agent, that the Respondent failed to monitor the drug effect and that the Respondent prescribed the " medication, that can cause weight gain, at the same time as prescribing another medication that can cause weight loss. The Committee found further that the Respondent failed to take any action in response to the Patient's elevated blood pressure nor did the Respondent obtain results or follow up on an MRI test in response to the Patient's vascular headaches. The Committee found the Respondent's overall care for all six Patients slipshod, unprofessional and lacking any continuity of care.

In reaching their Determination on the charges, the Committee found the Petitioner's expert witnesses, Irene Snow, M.D., and Bruce Maslow, M.D., qualified and credible. The Respondent presented no witnesses and the Respondent gave no testimony himself. The Committee drew a negative inference from the Respondent's decision against testifying.

After determining that the Respondent committed professional misconduct, the Committee then determined to assess a penalty under PHL § 230-a. The Committee voted to revoke the Respondent's License. The Committee determined that the Respondent's prescribing practices, his failure to order tests, his failure to address Patients' conditions and his failure to make necessary referrals placed the Respondent's Patients at risk.

Review History and Issues

The Committee rendered their Determination on February 16, 2006. Both parties then requested administrative review and provided review submissions to the ARB. The record on review included those submissions, the Committee's Determination and the hearing record.

The Petitioner requested that the ARB modify the Committee's Determination to find the Respondent guilty for gross negligence and gross incompetence in the care to all six Patients at issue in this case.

The Respondent challenges the Committee's Determination on procedural grounds, on sufficiency of the evidence and on penalty. The Respondent alleges that the Respondent could face criminal charges in relation to Patient A and that the procedures for physician disciplinary proceedings fail to provide the Respondent with the full rights that a criminal defendant would receive. The Respondent alleges further that the procedures in the disciplinary process interfere with the Respondent's other constitutional rights or jeopardize his Federal license. The Respondent also alleges that some procedures deny the Respondent due process, such as the provisions in PHL § 230 that allow the appointment of Department of Health employees as administrative officers for BPMC hearings and that provide confidentiality for the source of complaints against a licensee. On the evidence, the Respondent argues that the Petitioner failed to present testimony by qualified expert witnesses and that the evidence at hearing failed to establish that the Respondent practiced with negligence and incompetence on more than one occasion. On penalty, the Respondent argues that the Committee's findings fail to warrant so severe a penalty and the Respondent argues that no clear standard establishes when revocation constitutes a proper penalty. The Respondent asks that the ARB annul the Committee's Determination.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL §230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. The ARB affirms the Committee's Determination that the Respondent practiced with negligence on more than one occasion and incompetence on more than one occasion in treating all six Patients at issue in this proceeding. We modify the Committee's Determination to find that the Respondent practiced with gross negligence in treating Patient A and, on our own motion, we amend certain factual findings by the Committee. We affirm the Committee's Determination to revoke the Respondent's License.

The Respondent's procedural challenges all relate to what the Respondent alleges to be deficiencies in the disciplinary system for failure to provide the Respondent the full rights a criminal defendant would receive or for components in the disciplinary system that the Respondent alleges to interfere with the Respondent's due process rights, such as the provisions for appointing the administrative officer or the confidentiality for complaints. All the procedural mechanisms in the disciplinary system come from the provisions in PHL § 230 or New York Administrative Procedure Act Article 3-5 or Title 10 NYCRR Part 51. As an administrative appeals body, the ARB lacks the authority to invalidate a statute or a regulation, so we lack the authority to address the Respondent's challenges to the procedures under those statutes and

regulations. The ARB realizes that the Respondent may have had to raise those issues in this forum to preserve the issues for other review.

As to the evidence before the Committee, the only testimony that the Committee heard came from the Petitioner's experts. The Respondent called the Petitioner's experts unqualified, but the Respondent provided no evidence to contradict the Petitioner's experts' testimony. The unchallenged, expert testimony before the Committee provided sufficient evidence to demonstrate that the Respondent practiced with negligence on more than one occasion and incompetence on more than one occasion in treating the Patients at issue in this proceeding. The Committee made no error in relying upon the evidence in the record to make their findings and conclusions on the charges.

We modify the Committee's Determination and we hold that the Respondent practiced with gross negligence and gross incompetence in treating Patient A. The Respondent should have referred this Patient to an orthopedic surgeon after an MRI determined that a bone chip was causing pressure on the Patient's spine. The Respondent should have ordered an EKG after he diagnosed the Patient with atrial fibrillation. The Respondent should also have continued the Patient on the drug Lanoxin after the drug produced a normal sinus rhythm for the Patient. The Respondent should also have monitored the dosage and frequency of the number of analgesic narcotics that the Respondent prescribed for the Patient. The Respondent failed to make the referral, order the EKG, continue the Lanoxin and monitor the narcotics. The Respondent's failure constituted a gross departure from accepted medical practice and revealed a serious deficiency in the knowledge and skill level necessary to practice medicine safely.

On our own motion, we also modify the Committee's Factual Findings 26, 32 and 48. At Factual Finding 20, concerning the treatment for Patient B, the Committee made the finding that:

"A physician cannot legally prescribe methadone to a patient for treatment of opioid addiction".

We hold that this finding reflects the testimony from the record that the Committee cited in support of that finding. At Factual Findings 26, 32 and 48, the Committee made the Finding that:

"A physician cannot prescribe methadone".

The ARB finds that this Finding fails to reflect adequately the testimony that the Committee cited as the source for the Finding. For each Finding 26, 32 and 48, we amend the first sentence in each Finding to read:

"A physician cannot legally prescribe methadone to a patient for treatment of opioid addiction".

We make no changes to the remaining portions of those Findings.

We affirm the Committee's Determination to revoke the Respondent's License. The Respondent engaged in repeated and serious misconduct in treating these six Patients. The Respondent's conduct demonstrated a disregard for the Patients and the Respondent's prescribing practices placed the Patients at risk. The Respondent presented no evidence in mitigation and nothing in the record indicates that the Committee can protect the public from the Respondent's practice deficiencies by any measure other than removing the Respondent from practice.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB modifies the Committee's Determination to sustain the additional specifications that the Respondent practiced with gross negligence and gross incompetence.
3. The ARB affirms the Committee's Determination to revoke the Respondent's License.

Robert M. Briber
Thea Graves Pellman
Datta G. Wagle, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Martin Kosich, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Kosich.

Dated: June 3, 2006

Robert M. Briber

In the Matter of Martin Kosich, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Kosich.

Dated: May 31, **2006**

Thea Graves Pellman

In the Matter of Martin Kosich, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Kosich.

Dated: 5/31, **2006**

Datta G. Wagle, M.D.

In the Matter of Martin Kosich, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Kosich.

Dated: June 1, 2006

S L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Martin Kosich, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Kosich.

Dated: June 1, **2006**

Therese G. Lynch M.D

Therese G. Lynch, M.D.