NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

March 11, 2019

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Jeffrey Stuart Ryan, D.O.
Ryan Family Medicine
411 New Karner Road
Albany, New York 12205

Re: License No. 218584

Dear Dr. Ryan:

Enclosed is a copy of the New York State Board for Professional Medical Conduct (BPMC) Order No. 19-046. This order and any penalty provided therein goes into effect March 18, 2019.

Please direct any questions to: Board for Professional Medical Conduct, Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204, telephone # 518-402-0846.

Sincerely,

[redacted]

Robert A. Catalano, M.D.
Executive Secretary
Board for Professional Medical Conduct

Enclosure

cc: Jeffrey Hurd, Esq.
Burke, Scolamiero & Hurd, LLP
7 Washington Square
P.O. Box 15085
Albany, New York 12212-5085

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JEFFREY STUART RYAN, D.O.	BPMC# 19-046 CONSENT ORDER

Upon the application of (Respondent) JEFFREY STUART RYAN, D.O. in the attached Consent Agreement and Order, which is made a part of this Consent Order, it is

ORDERED, that the Consent Agreement, and its terms, are adopted and

it is further

ORDERED, that this Consent Order shall be effective upon issuance by the Board, either

by mailing of a copy of this Consent Order, either by first class mail to Respondent at the address in the attached Consent Agreement or by certified mail to Respondent's attorney, OR

upon facsimile transmission to Respondent or Respondent's attorney,

whichever is first.

SO ORDERED.

[redacted]

DATE: 03/07/2019

ARTHUR S. HENGERER, M.D.
Chair
State Board for Professional Medical Conduct

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JEFFREY STUART RYAN, D.O.	CONSENT AGREEMENT

JEFFREY STUART RYAN, D.O., represents that all of the following statements are true:

That on or about July 26, 2000, I was licensed to practice as a physician in the State of New York, and issued License No. 218584 by the New York State Education Department.

My current address is Ryan Family Medicine, 411 New Kamer Road, Albany, New York 12205, and I will advise the Director of the Office of Professional Medical Conduct of any change of address.

I understand that the New York State Board for Professional Medical Conduct (Board) has charged me with one or more specifications of professional misconduct, as set forth in a Statement of Charges, marked as Exhibit "A", attached to and part of this Consent Agreement.

I agree not to contest the allegations, in full satisfaction of the charges against me, and agree to the following penalty:

Pursuant to N.Y. Pub. Health Law § 230-a(1), I shall be subject to a Censure and Reprimand.

Pursuant to N.Y. Pub. Health Law § 230-a(9), I shall be placed on probation for a period of thirty-six (36) months, subject to the terms set forth in attached Exhibit "B."

Pursuant to N.Y. Pub. Health Law § 230-a(3), my license to practice medicine in New York State shall be limited to preclude the prescribing, administering, dispensing, ordering, manufacturing, distributing, possessing, or otherwise utilizing controlled substances in my practice. However, such limitation on possessing (solely for purposes of administration), administering, prescribing, and ordering will not apply to such activity when done solely for the treatment of patients in active hospice care, when 1) the eligibility of such patients for hospice care has been independently determined by a physician other than me, and such physician is wholly independent from me, not being in my employ, under my supervision, or otherwise under my direction or influence, and 2) such patient is an inpatient in a facility regulated under Article 28 of the Public Health Law, is a resident or outpatient of a recognized hospice care facility or organization, or is a homecare patient under the care and direction of an hospice care provider

organization, provided any such facility or organization is wholly independent of me, and not in any way under my direction or influence. In furtherance of the limitation, Respondent shall maintain, in a format that is acceptable to OPMC, a log of all ordering, prescribing, administering and/or dispensing of all controlled substances, which shall include the following information: the drug, the dose, quantity prescribed and directions for use, the patient's location, name and date of birth, the diagnosis, the name and office address of the diagnosing health care provider, the date that the drug was prescribed, the name and address of the hospice or home care services agency providing services to the patient, and such other information related to ordering, prescribing, administering and/or dispensing as may be requested by OPMC. The log shall be provided to OPMC on a quarterly basis, as directed by OPMC. OPMC may also request the log, together with any relevant patient records, to be provided immediately if deemed, in OPMC's sole discretion, necessary or appropriate.

I further agree that the Consent Order shall impose the following conditions:

That Respondent shall comply with each and every penalty imposed by this Order pursuant to N.Y. Pub. Health Law § 230-a.

That Respondent shall remain in continuous compliance with all requirements of N.Y. Educ Law § 6502 including but not limited to the requirements that a licensee shall register and continue to be registered with the New York State Education Department (except during periods of actual suspension) and that a licensee shall pay all registration fees. Respondent shall not exercise the option provided in N.Y. Educ. Law § 6502(4) to avoid registration and payment of fees. This condition shall take effect 120 days after the Consent Order's effective date and will continue so long as Respondent remains a licensee in New York State; and

That Respondent shall remain in continuous compliance with all requirements of N.Y. Pub. Health Law § 2995-a(4) and 10 NYCRR 1000.5, including but not limited to the requirements that a licensee shall: report to the department all information required by the Department to develop a public physician profile for the licensee; continue to notify the department of any change in profile information within 30 days of any change (or in the case of optional information, within 365 days of such change); and, in addition to such periodic reports and notification of any changes, update his or her profile information within six months prior to the expiration date of the licensee's registration period. Licensee shall submit changes to his or her physician profile information either electronically using the department's secure web site or on forms prescribed by the department, and licensee shall

attest to the truthfulness, completeness and correctness of any changes licensee submits to the department. This condition shall take effect 30 days after the Order's effective date and shall continue so long as Respondent remains a licensee in New York State. Respondent's failure to comply with this condition, if proven and found at a hearing pursuant to N.Y. Pub. Health Law § 230, shall constitute professional misconduct as defined in N.Y. Educ. Law § 6530(21) and N.Y. Educ. Law § 6530(29). Potential penalties for failure to comply with this condition may include all penalties for professional misconduct set forth in N.Y. Pub. Health Law § 230-a, including but not limited to: revocation or suspension of license, Censure and Reprimand, probation, public service and/or fines of up to $10,000 per specification of misconduct found; and

That Respondent shall provide the Director, Office of Professional Medical Conduct (OPMC), Riverview Center, 150 Broadway, Suite 355, Albany, New York 12204-2719, with the following information, in writing, and ensure that this information is kept current: a full description of Respondent's employment and practice; all professional and residential addresses and telephone numbers within and outside New York State; and all investigations, arrests, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility. Respondent shall notify OPMC, in writing, within 30 days of any additions to or changes in the required

information. This condition shall take effect 30 days after the Order's effective date and shall continue at all times until Respondent receives written notification from the Office of Professional Medical Conduct, Physician Monitoring Program, that OPMC has determined that Respondent has fully complied with and satisfied the requirements of the Order, regardless of tolling; and

That Respondent shall cooperate fully with the Office of Professional Medical Conduct (OPMC) in its administration and enforcement of this Consent Order and in its investigations of matters concerning Respondent. Respondent shall respond in a timely manner to all OPMC requests for written periodic verification of Respondent's compliance with this Consent Order. Respondent shall meet with a person designated by the Director of OPMC, as directed. Respondent shall respond promptly and provide all documents and information within Respondent's control, as directed. This condition shall take effect upon the Board's issuance of the Consent Order and will continue so long as Respondent remains licensed in New York State.

I stipulate that my failure to comply with any conditions of this Consent Order shall constitute misconduct as defined by N.Y. Educ. Law § 6530(29).

I agree that, if I am charged with professional misconduct in future, this Consent Agreement and Order shall be admitted into evidence in that proceeding.

I ask the Board to adopt this Consent Agreement.

I understand that if the Board does not adopt this Consent Agreement, none of its terms shall bind me or constitute an admission of any of the acts of alleged misconduct; this Consent Agreement shall not be used against me in any way and shall be kept in strict confidence; and the Board's denial shall be without prejudice to the pending disciplinary proceeding and the Board's final determination pursuant to the N.Y. Pub. Health Law.

I agree that, if the Board adopts this Consent Agreement, the Chair of the Board shall issue a Consent Order in accordance with its terms. I agree that this Consent Order shall take effect upon its issuance by the Board, either by mailing of a copy of the Consent Order by first class mail to me at the address in this Consent Agreement, or to my attorney by certified mail, OR upon facsimile transmission to me or my attorney, whichever is first. The Consent Order, this agreement, and all attached Exhibits shall be public documents, with only patient identities or other confidential information, if any, redacted. As public documents, they may be posted on the Department's website. OPMC shall report this action to the National Practitioner Data Bank and the Federation of State Medical Boards, and any other entities that the Director of OPMC shall deem appropriate.

I stipulate that the proposed sanction and Consent Order are authorized by N.Y. Pub. Health Law §§ 230 and 230-a, and that the Board and OPMC have the requisite powers to carry out all included terms. I ask the Board to adopt this Consent Agreement of my own free will and not under duress, compulsion or restraint. In consideration of the value to me of the Board's adoption of this Consent Agreement, allowing me to resolve this matter without the various risks and burdens of a hearing on the merits, I knowingly waive my right to contest the Consent Order for which I apply, whether administratively or judicially, I agree to be bound by the Consent Order, and I ask that the Board adopt this Consent Agreement.

I understand and agree that the attorney for the Department, the Director of OPMC and the Chair of the Board each retain complete discretion either to enter into the proposed agreement and Consent Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

DATE 2/20/19

[redacted]

JEFFREY STUART RYAN, D.O.
RESPONDENT

The undersigned agree to Respondent's attached Consent Agreement and to its proposed penalty, terms and conditions.

DATE: 2/27/19

[redacted]
JEFFREY HURD, ESQ.
Attorney for Respondent

DATE: 3/1/19

[redacted]
DAVID W. QUIST
Associate Attorney
Bureau of Professional Medical Conduct

DATE: 3/7/19

[redacted]
KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT "A"

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF JEFFREY STUART RYAN, D.O.	STATEMENT OF CHARGES

JEFFREY STUART RYAN, D.O., the Respondent, was authorized to practice medicine in New York State on or about July 26, 2000, by the issuance of license number 218584 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A (all patients are identified in the Appendix), a 33-year-old male when Respondent began treating him for depression and other conditions including chronic pancreatitis and gastritis from on or about March 2, 2006 to on or about April 27, 2015, just prior to Patient A's death of aspirational asphyxiation secondary to Fentanyl overdose on or about April 29, 2015. Respondent's care and treatment of Patient A failed to meet accepted standards of medical practice, in that:

1. Respondent failed, on one or more occasions, to adequately examine Patient A, including but not limited to on or about December 22, 2009, and/or on or about April 2, 2012.
2. Respondent failed to take an adequate medical history of Patient A on or about December 22, 2009.
3. On one or more occasions, including but not limited to on or about November 11, 2008, on or about March 6, 2012, on or about October 23, 2012, on or about November 15, 2012, and/or on or about March 11, 2014, Respondent failed to appropriately prescribe medications to Patient A, including but not limited to Lexapro (escitalopram), Oxycontin, and/or Fentanyl.

4. On one or more occasions, including but not limited to on or about December 22, 2008 and/or on or about March 6, 2012, Respondent failed to adequately counsel Patient A regarding his use of medications prescribed to other individuals, including but not limited to Provigil and/or benzodiazepines.
5. On one or more occasions, Respondent failed to adequately monitor Patient A's use of the medications prescribed, in response to Patient A's repeated efforts to refill prescriptions early, Patient A's loss of medications on more than one occasion, his possible use of other medications, and despite Patient A's history of prior drug and alcohol abuse.
6. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient A.

B. Respondent provided medical care to Patient B, a 29-year-old male when Respondent began treating him for thoracic disc degeneration and other conditions including asthma and alopecia, from on or about October 28, 2008 to on or about December 12, 2017. Respondent's care and treatment of Patient B failed to meet accepted standards of medical practice, in that:

1. On one or more occasions, Respondent failed to adequately examine Patient B, including but not limited to on or about July 29, 2009, on or about January 7, 2013, and/or on or about August 18, 2015.
2. Respondent failed to adequately evaluate, justify and/or document support for the ordering of laboratory testing for sexually transmitted diseases for Patient B on or about July 29, 2009.
3. Respondent diagnosed Patient B with "Congenital Spondylolysis Thoracic Region" on or about May 20, 2013 without adequate medical indication.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient B.

C. Respondent provided medical care to Patient C, a 39-year-old male when Respondent began treating him for chronic pain of the back, hip, and neck, and other

conditions including hypertension, hyperlipidemia, coronary artery disease, and congenital hypoplasia of the right leg, from on or about January 16, 2009 to on or about February 21, 2017. Respondent's care and treatment of Patient C failed to meet accepted standards of medical practice, in that:

1. On one or more occasions, Respondent failed to adequately examine Patient C, including but not limited to, on or about April 8, 2009, on or about December 4, 2009, and/or on or about July 5, 2012
2. Respondent failed to adequately manage Patient C's hypertension on or about January 12, 2016, on or about June 9, 2016 and/or on or about June 30, 2016.
3. On one or more occasions, Respondent failed to appropriately prescribe medications to Patient C, including but not limited to Lortab, hydrocodone, and/or Viagra.
4. Respondent failed to adequately evaluate, justify and/or document support for the ordering of testosterone studies on or about July 5, 2012.
5. Respondent failed to adequately evaluate and/or manage Patient C's positive toxicology screen for cocaine, dated on or about January 4, 2017.
6. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient C.

D. Respondent provided medical care to Patient D, a 39-year-old male when Respondent began treating him for chronic back pain and other back conditions following the removal of a spinal tumor several years earlier, from on or about April 16, 2009 to on or about December 4, 2013. Respondent's care and treatment of Patient D failed to meet accepted standards of medical practice, in that:

1. On one or more occasions, Respondent failed to adequately examine Patient D, including but not limited to, on or about May 11, 2009 and/or on or about April 26, 2011.
2. Respondent failed to justify and/or document the justification for treatment of Patient D with antibiotics on or about May 29, 2009, on or about October 9, 2009 and/or November 23, 2009, on or about March 23, 2010.

3. Respondent failed to justify and/or document the need for increased dosages of pain management medications, including but not limited to hydromorphone and oxycodone, for Patient D, including but not limited to on or about August 24, 2011.
4. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient D.

E. Respondent provided medical care to Patient E, a 23-year-old male when Respondent began treating him for polypharmacy abuse from on or about 1/11/11 to on or about 3/7/17. Respondent's care and treatment of Patient E failed to meet accepted standards of medical practice, in that:

1. Respondent failed to maintain a record which accurately reflects the evaluation and treatment of Patient E.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, and/or E and E.1.

SECOND SPECIFICATION
INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of:

1. The facts in Paragraphs A and A.1, A and A.2, A and A.3, A and A.4, A and A.5, A and A.6, B and B.1, B and B.2, B and B.3, B and B.4, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, C and C.6, D and D.1, D and D.2, D and D.3, D and D.4, and/or E and E.1.

THIRD SPECIFICATION
FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, as alleged in the facts of:

2. The facts in Paragraphs A and A.6, B and B.2, B and B.4, C and C.4, C and C.6, D and D.2, D and D.3, D and D.4, and/or E and E.1.

DATE: ~~January~~ March 1, 2019
Albany, New York

[redacted]

TIMOTHY A. MAHAR, ESQ.
Deputy Counsel
Bureau of Professional Medical Conduct

EXHIBIT "B"

Terms of Probation

1) Respondent's conduct shall conform to moral and professional standards of conduct and governing law. Any act of professional misconduct by Respondent as defined by N.Y. Educ. Law §§ 6530 or 6531 shall constitute a violation of probation and may subject Respondent to an action pursuant to N.Y. Pub. Health Law § 230(19).

2) Respondent shall cooperate fully with, and respond in a timely manner to, OPMC requests to provide written periodic verification of Respondent's compliance with the terms of this Consent Order. Upon the Director of OPMC's request, Respondent shall meet in person with the Director's designee.

3) Respondent's failure to pay any monetary penalty by the prescribed date shall subject Respondent to all provisions of law relating to debt collection by New York State, including but not limited to: the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits or licenses [Tax Law § 171(27); State Finance Law § 18; CPLR § 5001; Executive Law § 32].

4) The probation period shall toll when Respondent is not engaged in active medical practice in New York State for a period of 30 consecutive days or more. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in, or intends to leave, active medical practice in New York State for a consecutive 30 day period. Respondent shall then notify the Director again at least 14 days before returning to active practice. Upon Respondent's return to active practice in New York State, the probation period shall resume and Respondent shall fulfill any unfulfilled probation terms and such additional requirements as the Director may impose as reasonably relate to the matters set forth in Exhibit "A" or as are necessary to protect the public health.

5) The Director of OPMC may review Respondent's professional performance. This review may include but shall not be limited to: a review of office records, patient records, hospital charts, and/or electronic records; and interviews with or periodic visits with Respondent and staff at practice locations or OPMC offices.

6) Respondent shall adhere to federal and state guidelines and professional standards of care with respect to infection control practices. Respondent shall ensure education, training and oversight of all office personnel involved in medical care, with respect to these practices.

7) Respondent shall maintain complete and legible medical records that accurately reflect the evaluation and treatment of patients and contain all information required by State rules and regulations concerning controlled substances.

8) Within thirty days of the Consent Order's effective date, Respondent shall practice medicine only when monitored by a licensed physician, board certified in an appropriate specialty, ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC. Any medical practice in violation of this term shall constitute the unauthorized practice of medicine.

   a) Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no fewer than 20) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

   b) Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

   c) Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

   d) Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

9) Respondent shall enroll in and successfully complete a continuing education program as directed by the Office of Professional Medical Conduct. This continuing education program is subject to the Director of OPMC's prior written approval.

10) During the term of probation, the prescribing log required under this order will, in addition to being provided to OPMC as otherwise required by this order, will also be subject to review by Respondent's Practice Monitor. Respondent shall cause the Practice Monitor to examine this log, and include, as part of the Practice Monitor's review of the medical records of patients treated by Respondent, an examination of at least 10 medical records per month obtained through examination of the log entries.

11) Respondent shall comply with this Consent Order and all its terms, and shall bear all associated compliance costs. Upon receiving evidence of noncompliance with, or a violation of, these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding, and/or any other such proceeding authorized by law, against Respondent.