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

March 30, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Timothy J. Mahar, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Alan S. Levin, M.D.
395 Saratoga Road
Glenville, New York 12302

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5 Wembley Court, New Karner Road
P.O. Box 15054
Albany, New York 12212-5054

RE: In the Matter of Alan S. Levin, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 03-238) 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.

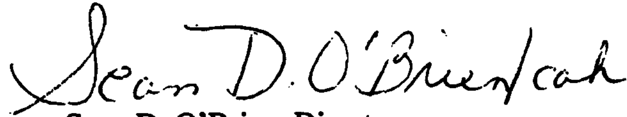
Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified 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, 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 **Alan S. Levin, 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. 03-238**

COPY

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

For the Department of Health (Petitioner): **Timothy J. Mahar, Esq.**
For the Respondent: **Maureen S. Bonnani, Esq.**

In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney 2004), the ARB determines the penalty to impose against the Respondent's license to practice medicine in New York State (License) for failure to provide acceptable medical care to seven patients. After a hearing below, a BPMC Committee found that the Respondent practiced medicine with gross negligence and negligence on more than one occasion and found that the Respondent failed to maintain accurate patient records. The Committee voted to suspend the Respondent's License for six months and to place the Respondent on probation for two and one-half years, under terms that appear at the Appendix to the Committee's Determination. In this review, the Petitioner asks that the ARB affirm additional charges and revoke the Respondent's License, while the Respondent argues that the Committee imposed an overly harsh penalty. After considering the hearing record and the parties' review submissions, the ARB affirms the Committee's Determination on the charges and on the six- month suspension. We vote to increase the probation to four and one-half years and we restrict the Respondent permanently to practice, under supervision, in a medical facility which the government operates or licenses.

Committee Determination on the Charges

The Petitioner commenced the proceeding by filing charges with BPMC alleging that the Respondent violated N. Y. Educ. Law §§ 6530(3-6) & 6530(32)(McKinney Supp. 2004) 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,
- practicing medicine with gross incompetence, and,
- failing to maintain accurate patient records.

The charges involved the care the Respondent provided to seven patients (Patients A-G). The record refers to the Patients by initials to protect patient privacy. A hearing on the charges followed, before the Committee that rendered the Determination now on review.

The Committee dismissed all charges alleging incompetence on more than one occasion and gross incompetence. The Committee sustained the charges that the Respondent failed to maintain accurate medical records for Patients A-G. The Committee noted that the Respondent acknowledged sloppy record-keeping practices (Hearing Committee Determination page 71). The Committee also sustained the charge that the Respondent practiced with gross negligence in treating Patient B. The Committee found that the Respondent failed to order appropriate diagnostic tests to evaluate the Patient's rectal bleeding and detect a mass in the Patient's anus. The Committee found no excuse for the Respondent's failure to perform routinely certain tests or to track down the cause for the Patient's persistent symptoms.

The Committee found that the Respondent practiced with negligence on more than one occasion in treating all the Patients. In addition to the findings on the care to Patient B, the Committee found that the Respondent failed to:

- monitor and/or treat the Patients adequately for such conditions as diabetes, renal disease, anxiety or back pain;
- follow-up indicated tests, procedures and evaluations; and,

- monitor Patients on certain medications.

The Committee found the Respondent's practice lackadaisical, sloppy and careless. The Committee concluded that the Respondent failed to exercise reasonable care under the circumstances, as opposed to not knowing the care he should have exercised.

In reaching their findings, the Committee found credible testimony by the Petitioner's medical expert, Lorne Becker, M.D., and the Respondent's expert, Anthony Marinello, M.D. The Committee noted that Dr. Marinello sometimes acknowledged that the Respondent failed to meet acceptable standards. The Committee found that the Respondent's testimony showed sufficient medical knowledge and skill, but the Committee concluded that the Respondent took the easy, less complicated treatment route.

The Committee voted to suspend the Respondent's License for three years, to stay the suspension for all but six months and to place the Respondent on probation for two and one-half years following the suspension. The probation terms appear at the Appendix to Committee's Determination and include the requirement that the Respondent practice with a monitor. The Committee stated that the Respondent's misconduct warranted a meaningful period on suspension. The Committee also concluded that the Respondent would benefit from time on probation and an appropriate educational program. The Committee concluded that the Respondent possesses medical skills that will provide value to the community in which the Respondent practices.

Review History and Issues

The Committee rendered their Determination on September 11, 2003. This proceeding commenced on September 25, 2003, when the ARB received the Respondent's Notice requesting a Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and the Respondent's brief and response brief. The record closed when the ARB received the response brief on November 3, 2003.

The Petitioner argues that the Committee made a Determination inconsistent with their findings. The Petitioner argues that the Committee's findings demonstrate that the Respondent also practiced with gross negligence in treating Patients A and C, with gross incompetence in treating Patients A-C and with incompetence on more than one occasion on treating Patients A-G. In addition to a request that the ARB sustain additional misconduct specifications, the Petitioner also requests that the ARB increase the penalty. The Petitioner argues that the Respondent lacks the ability to recognize and manage pathologies properly. The Petitioner argues that the Respondent poses a danger to patients and the Petitioner questions whether the Respondent possesses the motivation to reform his practice. The Petitioner asks that the ARB revoke the Respondent's License, or in the alternative, that the ARB suspend the Respondent's License until the Respondent completes retraining, or in the alternative, that the ARB limit the Respondent to practice in a medical facility holding a license pursuant to Pub. Health Law Article 28.

The Respondent argues that the Committee imposed an overly harsh penalty by suspending the Respondent's License. The Respondent characterized the penalty as inconsistent with the Committee's conclusions that the Respondent showed sufficient knowledge and skill and inconsistent with the Committee's finding about the Respondent being straightforward and candid. The Respondent opposes any increase in penalty and points to the Committee's findings to demonstrate that the Respondent has taken steps already to improve his practice.

Determination

The ARB has considered the record and the parties' briefs. We affirm the Committee's Determination that the Respondent practiced with gross negligence in treating Patient B and

with negligence on more than one occasion in treating Patients A-G. We also affirm the Committee's Determination that the Respondent failed to maintain accurate records for Patients A-G. Neither party challenged the Committee's Determination to sustain those charges. We reject the Petitioner's request that we affirm additional charges. We vote 3-2 to modify the Committee's Determination suspending the Respondent's License, staying the suspension and placing the Respondent on probation. We place a permanent limitation on the Respondent's License by restricting the Respondent to practice under supervision in a facility, which the government operates or the government licenses.

Additional Charges: The ARB agrees with the Committee that the Respondent committed egregious misconduct only in his failure to order appropriate diagnostic tests to evaluate the Patient B's rectal bleeding and detect a mass in the Patient's anus. The conduct with regard to Patients A and C failed to meet the threshold for egregious misconduct, despite the Committee's use of words such as "serious' to describe the Respondent's care for Patients A and C. We affirm the Committee's Determination to hold that the Respondent practiced with gross negligence in treating Patient B and we affirm the Committee's Determination to dismiss the charges that the Respondent practiced with gross negligence in treating Patients A and C.

We also agree with the Committee that the facts and the record support the Committee's conclusions that the Respondent's conduct in these cases demonstrated negligence rather than incompetence. The Committee found that the Respondent exhibited skill and knowledge, but also lackadaisical, sloppy and careless practice. The Respondent knew the appropriate care, but he failed to provide it and he followed the less complicated treatment route.

Penalty: In reviewing a Committee's Determination, the ARB may substitute our judgement 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) and we may choose to substitute that judgement and impose a more severe sanction than the Committee, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). We elect to exercise that authority in this case.

By a 3-2 vote, the ARB rejects the Petitioner's request that we revoke the Respondent's License or that we suspend the Respondent's License until such time as the Respondent completes retraining successfully. The majority concludes that the Petitioner based the request for those sanctions in large part on the Petitioner's argument that the Respondent practiced with repeated and egregious incompetence and that the Respondent practiced with gross negligence in treating more than one patient. The ARB has already rejected those arguments. The majority agrees with the Committee that the Respondent possesses skills worth preserving, but that the Respondent requires a serious enough sanction to change the Respondent's practice pattern. The two dissenters find no mitigating factors in this case and they vote to revoke the Respondent's License.

The majority rejects retraining as a sanction, because the Committee found the Respondent possessed skills. We find retraining an inappropriate means to cure sloppiness and the tendency to follow the easy, less complicated treatment route. The Respondent requires a wake-up call to change his conduct and the Respondent requires observation and supervision to assure that he will abandon his unacceptable practice pattern permanently. The majority concludes that actual time on suspension will provide the Respondent the time to consider that he must change his practice and will demonstrate that the failure to correct his practice should result in the Respondent's permanent exclusion from medical practice in New York. We also agree with the Committee that the Respondent's conduct warrants actual time on suspension. Egregious misconduct, even involving a single patient procedure, can warrant a penalty that includes both

an actual practice suspension and a permanent license restriction, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The Respondent argued that he has already taken steps to correct his problems, but the Respondent identified only changes in record-keeping as the steps he has taken. The Committee concluded that the Respondent's conduct arose from far more than record-keeping errors.

The majority also agrees with the Committee that time on probation, with a monitor, will also benefit the Respondent. The majority concludes, however, that the Respondent will benefit from probation for a longer probation period than that which the Committee imposed. The majority votes to suspend the Respondent's License for five years, to stay the suspension for all but six months and to place the Respondent on probation for the four years and six months during the stayed suspension. We retain the probation terms that the Committee imposed in the Appendix to their Determination.

The majority also concludes that the Respondent requires permanent supervision to assure that the Respondent abandons his lackadaisical and sloppy practice pattern. Under Pub. Health Law §§ 230(18)(a) & 230-a(9), probation terms may include monitoring. We may only impose probation, however, for a limited period. The majority concludes that to assure that the Respondent will practice in a setting with permanent supervision, we must restrict the Respondent to practice as an employee in a medical facility that a.) the government operates (such as the Veteran's Administration) or that b.) holds a government license (such as a general hospital or clinic with an operating certificate pursuant to Pub. Health Law Article 28). Statutes and regulations guarantee oversight, supervision and quality assurance in such practice settings. The majority concludes that such medical facilities will provide the supervision necessary to assure that the Respondent will use his skills in an appropriate manner.

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 by practicing with gross negligence and negligence on more than one occasion and by failing to maintain accurate records.
2. The ARB modifies the Committee's Determination by suspending the Respondent's License for five years, staying the suspension for all but six months and placing the Respondent's License on probation for four and one-half years, under the terms that appear at the Appendix to the Committee's Determination.
3. The ARB places a permanent limitation on the Respondent's License to restrict him to practice, under supervision, in a medical facility that the government licenses or that the government operates.

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 Alan S. Levin, M.D.

Stanley L. Grossman, as ARB Member affirms that he took part in the deliberations in this case and that this Determination and Order reflects the decision by the ARB majority in the Matter of Dr. Levin.

Dated: 03|30|04, 2004

S L Grossman M.D

Stanley L Grossman, M.D.

In the Matter of Alan S. Levin, M.D.

Thea Graves Pellman, an ARB Member affirms that she took part in the deliberations in this case and this Determination and Order reflects the decision by the ARB majority in the Matter of Dr. Levin.

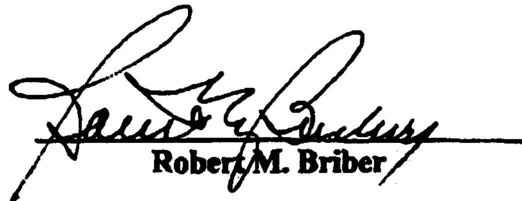
Dated: Mar 24, **2004**

Thea Graves Pellman

In the Matter of Alan S. Levin, M.D.

Robert M. Briber, an ARB Member, affirms that he took part in the deliberations in this case and that this Determination and Order reflects the decision by the ARB majority in the Matter of Dr. Levin.

Dated: March 24, 2004

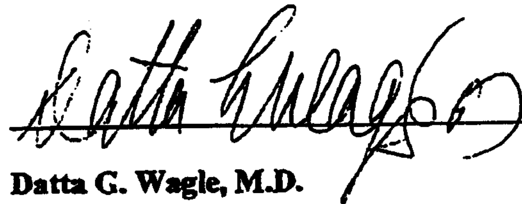


Robert M. Briber

In the Matter of Alan S. Levin, M.D.

Datta G. Wagle, M.D., an ARB Member affirms that he took part in the deliberations in this case and that this Determination and Order reflects the decision by the ARB majority in the Matter of Dr. Levin.

Dated: 3/23/, **2004**



Datta G. Wagle, M.D.

In the Matter of Alan S. Levin, M.D.

Therese G. Lynch, M.D., an ARB Member affirms that she took part in the deliberations in this case and that this Determination and Order reflects the decision of the ARB majority in the Matter of Dr. Levin.

Dated: March 23, 2004

Therese G Lynch M.D.

Therese G. Lynch, M.D.