

THE ALTERNATIVE MEDICAL PRACTICE ACT: DOES IT ADEQUATELY PROTECT THE RIGHT OF PHYSICIANS TO USE COMPLEMENTARY AND ALTERNATIVE MEDICINE?

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INTRODUCTION

The early 1990s witnessed an explosion of the American consumer's interest in complementary and alternative medicine (CAM).¹ In 1993, a survey published in the *New England Journal of Medicine* (NEJM) sparked the attention of the entire healthcare industry with a finding that more Americans consulted CAM providers than conventional physicians.² According to the survey, consumers paid \$10.3 billion in out-of-pocket expenses to CAM providers representing a large share of the \$23.5 billion paid in out-of-pocket expenses for all physicians' services in the United States.³ A follow-up survey conducted in 1997 indicated "dramatic increases in use and expenditures associated with alternative medical care."⁴ Researchers have

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¹ See generally Kathleen M. Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185 (1998) (discussing increased CAM use and expenditures due to increased patient demand); David M. Eisenberg, *Trends in Alternative Medicine in the United States, 1990-1997*, 280 JAMA 1569 (1998) (discussing the expansion of CAM).

² David M. Eisenberg, *Unconventional Medicine in the United States—Prevalence, Costs, and Patterns of Use*, 328 NEW ENG. J. MED. 246, 251 (1993). The survey was conducted in 1990.

³ *Id.* at 250-51.

⁴ Eisenberg, *supra* note 1, at 1575. The study revealed that from 1990-1997 there was an increase of use of CAM from 33.8% to 42.1% and an increase in total visits to CAM practitioners from 427 million to 629 million. Expenditures increased 45.2% and conservatively estimated at 21.2 billion in 1997 with 12.2 billion paid out

estimated that consumer spending on CAM will grow by as much as thirty percent annually.⁵ Health maintenance organizations (HMOs) and the broader insurance industry have also recognized this consumer demand for alternative health care along with its concomitant monetary expenditures. Kaiser Permanente, the largest HMO, Oxford Health Plans, Western Life, Mutual of Omaha, and Blue Cross Blue Shield now offer some level of reimbursement for alternative therapies.⁶

In 1992, under the auspices of the National Institutes of Health,⁷ Congress authorized the establishment of what is now called the National Center for Complementary and Alternative Medicine (NCCAM)⁸ The primary purpose of NCCAM is "to facilitate the evaluation of alternative medical treatment modalities."⁹ From an initial budget of \$3.5 million, congressional appropriations for the 2000 fiscal year have increased to \$68.4 million.¹⁰

of pocket. In 1990, it was estimated that 60 million people used at least 1 of 16 alternative therapies as compared to 83 million in 1997. *Id.* at 1569.

⁵ See David M. Studdert et al., *Medical Malpractice Implications of Alternative Medicine*, 280 JAMA 1610 (1998). But see Chris Rauber, *Open to Alternative: Pressured by Consumers Demand, More Health Plans Are Embracing Nontraditional Treatment Options*, 50 MOD. HEALTHCARE, Sept. 7, 1998, at 8 (noting that others have more conservatively estimated the annual growth rate at fifteen percent).

⁶ See Aimee Doyle, *Alternative Medicine and Medical Malpractice Emerging Issues*, 22 J. LEGAL MED. 533, 539 n.33 (2001); see also, Studdert, *supra* note 5, at 1610.

⁷ See *id.*; see also Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, 112 Stat. 2681 (1998); Boozang, *supra* note 1, at 189; Doyle, *supra* note 6, at 538.

⁸ What was originally established as the Office of Alternative Medicine has been renamed several times and is currently called the National Center for Complementary and Alternative Medicine. See National Center for Complementary and Alternative Medicine, *Important Events in NCCAM History*, at <http://nccam.nih.gov/about/ataglance/timeline.htm> (last modified May 23, 2002).

⁹ Kristen J. Josefek, *Alternative Medicine's Roadmap to Mainstream*, 26 AM. J.L. & MED. 295, 296 n.13; see National Institutes of Health, *NCCAM Legislative Chronology, Mission*, at <http://www.nih.gov/about/almanac/organization/NCCAM.htm> (last visited July 12, 2002); see also Lori B. Andrews, *The Shadow Healthcare System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1288 (1996); Doyle, *supra* note 6, at 538.

¹⁰ See Doyle, *supra* note 6, at 538; Josefek, *supra* note 9, at 296. NCCAM's 2002 appropriation is \$104.6 million. This figure reflects a 17.3% increase over the 2001 appropriation of \$89.2 million. See National Center for Complementary and Alternative Medicine, *FY 2003 Budget*, available at <http://nccam.nih.gov/about/congressional/2003.pdf> (last visited Feb. 4, 2003).

Despite the tumultuous relationship between conventional medicine and CAM,¹¹ the medical community has begun to seriously examine CAM and to incorporate it into mainstream healthcare. “The American Medical Association (AMA) has recognized the need for medical schools to respond to the growing interest in alternative health care practices.”¹² Approximately sixty percent of United States’ medical schools now offer courses in complementary or alternative medicine.¹³ Research has shown that eighty percent of medical students and seventy percent of family physicians wish to receive training in CAM therapies,¹⁴ and nearly sixty percent of conventional physicians have either made referrals or are willing to refer their patients to CAM practitioners.¹⁵ Further, the Group on Educational Affairs of the Association of American Medical Colleges, the Society of Teachers of Family Medicine, and the American Public Health Association have formed CAM special interest groups.¹⁶

¹¹ See *Wilk v. Am. Med. Ass’n*, 719 F.2d 207, 211 (7th Cir. 1983); JOHN ROBBINS, RECLAIMING OUR HEALTH: EXPLODING THE MEDICAL MYTH AND EMBRACING THE SOURCE OF TRUE HEALING 7–9 (H J Kramer 1996); see also Andrews, *supra* note 9, at 1288, 1291; Boozang, *supra* note 1, at 185; Josefek, *supra* note 9, at 296–97.

¹² Miriam S. Wetzel, *Courses Involving CAM at United States’ Medical Schools*, 280 JAMA 784, 784 (1998).

¹³ See *id.* As of the fall of 1998 seventy-five of the 117 medical schools that responded to the survey, conducted by Drs. Wetzel, Eisenberg, and Kaptchuk, “reported offering elective courses in complementary or alternative medicine or including these topics in required courses.” *Id.*; see also Richard and Hinda Rosenthal Center for Complementary and Alternative Medicine, *Complementary and Alternative Medicine Course Taught at United States’ Medical Schools*, at http://www.rosenthal.hs.columbia.edu/MD_Courses.html (last visited Mar. 26, 2003).

¹⁴ See *CAM Facts: Complementary and Alternative Medicine in the United States*, at <http://www.healthlobby.com/confacts.html> (citing Wayne B. Jonas, *Remarks from the NIH Office of Alternative Medicine* (1997) (80% of medical students want training in CAM)); Brian M. Berman, *Physicians’ Attitudes Toward Complementary or Alternative Medicine: A Regional Survey*, J. AM. BOARD FAM. PRAC., Sept.–Oct. 1995 (70% of family physicians want training in CAM); see also Wetzel, *supra* note 12, at 786.

¹⁵ See Berman, *supra* note 14, at 364–66; see also Doyle, *supra* note 6, at 534 (citing J. Borkan et al., *Referrals for Alternative Therapies*, 39 J. FAM. PRAC. 545 (1994)); Hassan Rifaat, *A Closer Look: Integrating Alternative and Traditional Medicine*, 44 RISK MGMT. 62 (1997) (reporting that “[a] survey by the Office of Alternative Medicine found that over half of the conventional physicians in the United States have recommended or tried alternative medicine”); Wetzel, *supra* note 12, at 786.

¹⁶ Wetzel, *supra* note 12, at 784.

The overwhelming consumer interest in CAM and conventional medicine's courtship of CAM presents many challenges for physicians who have integrated or may in the future integrate CAM, in whole or in part, into their medical practice. Not surprisingly, courts, state legislators, and administrative bodies have been increasingly involved in defining the legal parameters of CAM. The differing views underlying organized medicine and unorthodox healthcare practice have led to a dilemma for legal decision makers.¹⁷ This professional rivalry has historically led courts, legislators, and administrative bodies to examine CAM practices through the perspective of conventional medicine.¹⁸ "The legal paradigm to date thus mirrors biomedicine's historical view of holistic practice as deviant, suspect, or 'on the fringe.'" ¹⁹ At the core of the lingering rivalry is conventional medicine's view that CAM's efficacy remains largely unproven.²⁰

Despite the heated debate of the efficacy of CAM therapies, physicians have integrated CAM therapies into their practices either by performing the therapy themselves or by referring their patients to a CAM practitioner. Malpractice liability and exposure to disciplinary action for unprofessional conduct have concerned these physicians, as well as those who are contemplating the integration of CAM therapies into their practice.

Part I of this Article examines state regulatory powers by providing an overview of the physician's scope of practice. It

¹⁷ See MICHAEL H. COHEN, COMPLEMENTARY & ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES 17-23 (1998); see also *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 211 (7th Cir. 1983); Andrews, *supra* note 9, at 1288-89.

¹⁸ COHEN, *supra* note 17, at 18. For example, the standard applied by the courts and state medical boards asks whether the physician's conduct was consistent with prevailing acceptable medical practices.

¹⁹ *Id.* at 23.

²⁰ Boozang, *supra* note 1, at 185 ("Alternative medicine's successful entry into Western practice depends on convincing conventional medicine of the efficacy of alternative treatments, a task that remains largely undone."). See generally *id.* at 185-93 (noting arguments against the integration of CAM by physicians); see also Michael H. Cohen & David M. Eisenberg, *Potential Physician Malpractice Liability Associated with Complementary and Integrative Medical Therapies*, 136 ANNALS INTERNAL MED. 596 (2002) ("[P]hysicians reviewing the integration of CAM therapies into conventional care should determine the extent to which the evidence reported in the scientific and medical literature supports both safety and efficacy . . ."); Studdert, *supra* note 5, at 1610.

provides an analysis of the disciplinary procedures experienced by physicians facing charges of unprofessional conduct arising from their integration of CAM therapy. Particular attention is given to specific CAM practices and the standard of care adopted by state medical boards to determine if unprofessional conduct has occurred. Also discussed is the permissible scope of the investigation and the medical board's power to conduct a comprehensive medical review and issue *subpoenae duces tecum*. Part II offers both judicial and legislative proposals for reform. This Article concludes that reforms are necessary to ensure the right of physicians to use effective innovative medicine and to protect patients' rights to choose their medical treatments.

This Article also provides a thorough discussion of the various legal issues confronting physicians who have integrated or are considering integrating CAM into their conventional medical practice, in whole or in part, and it offers several recommendations for providing greater protection to CAM physicians who not only cause no harm to their patients but also sincerely intend to facilitate their return to wellness.

I. STATE REGULATION OF SPECIFIC CAM PRACTICES

The United States Supreme Court has held that the police power of the states allows them to regulate the practice of medicine in order to protect the health, safety, and welfare of its citizens.²¹ Through this police power, states have passed legislation controlling the health care profession by defining the qualifications required to practice within the state.²² Each state's legislation broadly defines the practice of medicine.²³ For example, New York defines the practice of medicine as "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition,"²⁴ and California authorizes holders of a physician's and surgeon's

²¹ See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 38 (1905); *Dent v. West Virginia*, 129 U.S. 114, 128 (1889).

²² See N.Y. EDUC. LAW § 6524 (McKinney 2001) (requirements to qualify for a license as a physician); CAL. BUS. & PROF. CODE §§ 2080-2099 (West 1998) (requirements for a physician's or surgeon's certificate).

²³ See Michael H. Cohen, *Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes*, 38 ARIZ. L. REV. 83, 90 (asserting that "broad definitions of 'practicing medicine' codify orthodox medicine's historical dominance over the provision of health care").

²⁴ N.Y. EDUC. LAW § 6521 (McKinney 2001).

certificate to "use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions."²⁵ A license to practice medicine also requires physicians to comply with the state's standard of professional conduct.²⁶ Unprofessional conduct may include matters such as incompetence, negligence, breach of patient confidentiality, practicing beyond the scope permitted by law, conviction of a crime, and prohibited fee splitting.²⁷ Legislation may also include special provisions defining unprofessional conduct for the practice of medicine specifically.²⁸ Many state regulations also proscribe any departure from standards of acceptable and prevailing medical practice.²⁹

Since the practice of medicine is broadly defined, physicians are provided with the broadest scope of practice among health care providers.³⁰ Physicians attempting to integrate a CAM therapy into their conventional practice often learn, however, that their scope of practice is not unlimited. In most reported cases of CAM integration, the physicians risked having their licenses suspended or revoked, even though their patients were neither harmed nor complained to the medical board. In fact, in several cases, the patients provided informed consent and supported the physician before the medical board. These cases can be divided into several types of CAM therapies, including homeopathy, nutritional therapy, ozone and nutrition, and chelation.

A. Homeopathy

In *Metzler v. New York State Board for Professional Medical Conduct*,³¹ a physician requested judicial review of a

²⁵ CAL. BUS. & PROF. CODE § 2051 (West 1998).

²⁶ This standard is typically defined by enumerating conduct that is considered to be unprofessional. See, e.g., N.Y. COMP. CODES R. & REGS. tit. 8, §§ 29.1, 29.4 (McKinney 2000); CAL. BUS. & PROF. CODE § 2234 (West 1998).

²⁷ See N.Y. COMP. CODES R. & REGS. tit. 8, §§ 29.1, 29.4 (McKinney 2000).

²⁸ See *id.* § 29.4.

²⁹ See, e.g., *In re Guess*, 393 S.E.2d 833, 835 (N.C. 1990), (noting that North Carolina statutory law, N.C. GEN. STAT. § 90-14(a)(6) (1985), proscribes departure from accepted medical standards).

³⁰ See Cohen, *supra* note 23, at 90-91; see also COHEN, *supra* note 17, at 40.

³¹ 203 A.D.2d 617, 610 N.Y.S.2d 334 (3d Dep't 1994).

determination by the Administrative Review Board for Professional Conduct (ARB) that revoked his license to practice in New York.³² The ARB sustained the hearing committee's findings that the physician did "not practice orthodox or allopathic medicine but practice[d] homeopathy."³³ Further, "the [c]ommittee noted that '[h]omeopathy is not recognized in New York State as a separate branch of medicine nor is [the petitioner] separately licensed as a homeopathic physician.'³⁴ The physician argued that the hearing committee and the ARB applied the standard of care which was "applicable only to orthodox or allopathic medicine rather than to the homeopathic medicine" in which he engaged.³⁵

The physician also challenged the finding of misconduct on the ground that the four patients whose care was at issue consented to the physician's exclusive practice of homeopathy.³⁶ The appellate court found "such contention to be wholly without merit because it is well settled that a patient's consent to or even insistence upon a certain treatment does not relieve a physician from the obligation of treating the patient with the usual standard of care"³⁷ and affirmed the ARB's decision to revoke the physician's license.³⁸

In *In re Guess*,³⁹ Dr. Guess was a licensed physician who practiced family medicine in North Carolina.⁴⁰ The State Board of Medical Examiners revoked Dr. Guess's license because he integrated homeopathy into his medical practice.⁴¹ The board concluded that the "practice of homeopathy 'departs from and does not conform to the standards of acceptable and prevailing

³² *Id.* at 617, 610 N.Y.S.2d at 334.

³³ *Id.*, 610 N.Y.S.2d at 335. The petitioner described "homeopathy" as "treating the restrictions the person has in mastering life." *Id.*, 610 N.Y.S.2d at 335.

³⁴ *Id.* at 618, 610 N.Y.S.2d at 335. The committee concluded that the physician's treatment of an AIDS patient who died from pneumocystic pneumonia "did not meet the minimum standards of acceptable medical practice." *Id.*, 610 N.Y.S.2d at 335.

³⁵ *Id.*, 610 N.Y.S.2d at 336.

³⁶ *Id.* at 619, 610 N.Y.S.2d at 336.

³⁷ *Id.*, 610 N.Y.S.2d at 336 (citations omitted). The facts in *Metzler* indicate neither the specific conduct or lack of care that may have contributed to the death of one patient nor whether any of the four patients complained to any medical board.

³⁸ *Id.*, 610 N.Y.S.2d at 336.

³⁹ 393 S.E.2d 833, 834 (N.C. 1990).

⁴⁰ *Id.* at 834.

⁴¹ *Id.* at 835.

medical practice in . . . [the] State [of North Carolina].’⁴² The trial court, court of appeals, and the dissenting justice on the North Carolina Supreme Court maintained that the statutory scheme was intended to protect the public from detrimental conduct.⁴³ In coming to this conclusion, the dissent argued that statutory protection did not attach to the mere integration of CAM practices because “[t]he common thread running through each of these [statutory] reasons for revocation of a [medical] license is the threat or potential for harm to patients and the public.”⁴⁴ The majority of the North Carolina Supreme Court, however, concluded that the legislature intended to protect the public from the general risk of endangerment that “is *inherent* in any practices which fail to conform to the standards of ‘acceptable and prevailing’ medical practice in North Carolina.”⁴⁵ Neither the *Metzler* nor the *Guess* court defined what may be “acceptable and prevailing medical practice.”⁴⁶

B. Nutritional Therapy

In *Matter of Gonzalez v. New York State Department of Health*,⁴⁷ a physician treated mostly “patients with advanced and incurable cancer.”⁴⁸ The Office of Professional Medical Conduct (OPMC) brought charges against the physician for incompetence

⁴² *Id.* The North Carolina statute at issue, N.C. GEN. STAT. § 90-14(a)(6) (1985), stated that a departure from the standards of acceptable and prevailing medical practice is unprofessional conduct “irrespective of whether or not a patient is injured thereby.” *Id.* at 836. There were no allegations of harm to any of Dr. Guess’s patients. Indeed, there was evidence that several patients who were unable to obtain relief from conventional medicine found relief from Dr. Guess’s homeopathic treatments. *Id.* The dissenting justice remarked that Dr. Guess was “a highly qualified practicing physician who use[d] homeopathic medicines as a last resort when allopathic medicines are not successful.” *Id.* at 841 (quoting N.C. GEN. STAT. § 90-14(a)(6) (1985)).

⁴³ *Id.* at 836. The dissenting justice enumerated the statutory basis upon which a physician’s license might be suspended or revoked. *Id.* at 840–41.

⁴⁴ *Id.* at 840–41.

⁴⁵ *Id.* at 837. Several physicians testified before the board that “homeopathy was not an acceptable and prevailing system of medical practice in North Carolina.” *Id.* at 835. Dr. Guess had submitted evidence that at least three states and many foreign countries recognize homeopathy. *Id.* The dissenting justice raised the issue “of how the acceptable and prevailing practice can be improved in North Carolina if we do not even consider what happens in other states and countries.” *Id.* at 841.

⁴⁶ See *infra* text accompanying notes 212–57 for the standards to be applied in disciplinary proceedings.

⁴⁷ 232 A.D.2d 886, 648 N.Y.S.2d 827 (3d Dep’t 1996).

⁴⁸ *Id.* at 886, 648 N.Y.S.2d at 829.

and negligence based upon the physician's treatment of six patients with the disease.⁴⁹ Each patient had either exhausted or rejected conventional therapy.⁵⁰ "The [h]earing [c]ommittee ordered the suspension of petitioner's license to practice medicine for three years but stayed the suspension subject to petitioner's compliance with certain probationary conditions."⁵¹ Like the court in *Metzler*,⁵² the *Gonzalez* court held that despite a patient's consent, the physician was required to comply with "the usual standard of care."⁵³ In addition, the facts of neither case indicated whether any patient was harmed or who filed the complaints.⁵⁴

C. Ozone and Nutrition

The physician in *Atkins v. Guest*⁵⁵ treated cancer patients with a combination of ozone therapy and nutritional supplements.⁵⁶ An emergency room physician filed a complaint after Dr. Atkins sent his patient to the hospital following an ozone treatment.⁵⁷ The patient was treated "in a hyperbaric chamber and was eventually released with no apparent side effects or injuries."⁵⁸

⁴⁹ *Id.*, 648 N.Y.S.2d at 829. The hearing committee found that the physician failed to "(1) perform appropriate assessments . . . , (2) perform adequate neurological evaluations . . . , (3) perform an adequate physical examination . . . , (4) obtain adequate laboratory or radiological evaluations . . . , (5) perform sufficient follow-up monitoring . . . , and (6) perform sufficiently frequent follow-up evaluations." *Id.* at 887, 648 N.Y.S.2d at 829.

⁵⁰ *Id.* at 886, 648 N.Y.S.2d at 829.

⁵¹ *Id.* at 887, 648 N.Y.S.2d at 829. The conditions included supervision, completion of a retraining program, and satisfaction of 200 hours of community service. *See id.*, 648 N.Y.S.2d at 829.

⁵² *See Metzler v. N.Y. State Bd. Prof'l Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.2d 334, 336 (3d Dep't 1994).

⁵³ *Gonzalez*, 232 A.D.2d at 888, 648 N.Y.S.2d at 830.

⁵⁴ The applicable New York statute requires that the name of the complainant is to be kept confidential. N.Y. PUB. HEALTH LAW § 230(11)(a) (McKinney 1996). However, on occasion, the court has indicated that the complainant was another physician. *See, e.g., Atkins v. Guest*, 158 Misc. 2d 426, 427, 601 N.Y.S.2d 234, 235 (Sup. Ct. N.Y. County 1993); *infra* text accompanying notes 224-42.

⁵⁵ 158 Misc. 2d 426, 601 N.Y.S.2d 235.

⁵⁶ *Id.* at 427, 601 N.Y.S.2d at 235.

⁵⁷ *Id.* at 428, 601 N.Y.S.2d at 236.

⁵⁸ *Id.*, 601 N.Y.S.2d at 236. "The hyperbaric chamber is more commonly known as the decompression chamber, and is most often used to treat scuba divers suffering from the 'bends.'" *Id.*, 601 N.Y.S.2d at 236.

Dr. Atkins moved to quash a *subpoena duces tecum* for the patient's medical records issued by the OPMC.⁵⁹ Dr. Atkins claimed that the OPMC did not meet the necessary minimum requirements for the issuance of a subpoena.⁶⁰ He also pointed out that the patient specifically requested, based on her statutory confidentiality privilege, that her personal medical records not be released.⁶¹ The court denied the motion to quash the subpoena and rejected Dr. Atkins's "assertion that he cannot legally be found negligent or incompetent."⁶² The court left the determination of negligence or incompetence to the discretion of the New York State Board for Professional Conduct.⁶³

D. Chelation

In *State Board of Medical Examiners v. Rogers*,⁶⁴ Dr. Rogers was ordered by the Brevard County Medical Association to discontinue his employment of chelation treatment to remedy arteriosclerosis.⁶⁵ After refusing to discontinue his use of chelation treatments, the physician was expelled from the Brevard County Medical Association.⁶⁶ Subsequent to the expulsion, an administrative complaint was lodged against the physician for unprofessional conduct.⁶⁷ The Florida Supreme Court reviewed the nature and history of chelation therapy and noted that many experts agreed that chelation was efficacious.⁶⁸

The Florida Supreme Court affirmed the district court's determination that the Board of Medical Examiners' action "unreasonably interfere[d] with Dr. Rogers' right to practice medicine by curtailing the exercise of his professional judgment to administer chelation therapy."⁶⁹ The court acknowledged that the state's power "to regulate the practice of medicine for the

⁵⁹ *Id.*, 601 N.Y.S.2d at 236.

⁶⁰ *Id.* at 429, 601 N.Y.S.2d at 236.

⁶¹ *Id.* at 428, 601 N.Y.S.2d at 236; *see also* N.Y. PUB. HEALTH LAW § 230(11)(a) (McKinney 1996).

⁶² *Atkins*, 158 Misc. 2d at 431, 601 N.Y.S.2d at 238.

⁶³ *Id.* at 431, 601 N.Y.S.2d at 238.

⁶⁴ 387 So. 2d 937 (Fla. 1980).

⁶⁵ *Id.* at 937-38. Chelation therapy involves the use of intravenous injections to treat the hardening of arteries. *Id.* at 938 n.2.

⁶⁶ *Id.* at 938.

⁶⁷ *Id.*

⁶⁸ *Id.* at 939.

⁶⁹ *Id.*

benefit of the public health and welfare . . . is not unrestricted."⁷⁰ The court concluded that the medical board's decision was not reasonably related to the public health and welfare because of a lack of evidence that chelation therapy was harmful.⁷¹ The court found that Dr. Rogers fully informed his patients about chelation including the possibility of no improvement and noted that there was no evidence of either fraud or deception by Dr. Rogers upon his patients.⁷²

II. STATE MEDICAL FREEDOM ACTS

Curiosity, if not outright interest in CAM, was aroused by two studies published during the 1990s.⁷³ This recent trend toward understanding and integrating CAM into mainstream medicine follows on the heels of 150 years of strong opposition, and in some cases hostility, to CAM.⁷⁴ Conventional medicine practitioners, mostly through the American Medical Association, have attempted to discredit the practices of midwives,⁷⁵ homeopaths,⁷⁶ chiropractors,⁷⁷ acupuncturists,⁷⁸ and naturopaths.⁷⁹

Over the years, the AMA has succeeded in its early goals of dominance in the field of medicine. Through the concerted efforts of the AMA, all other healthcare providers were labeled as cultists, charlatans, and quacks.⁸⁰ Since the early 1900s, the AMA's goal was to become an organization " 'whose power to

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *Id.*

⁷³ See Eisenberg, *Trends in Alternative Medicine*, *supra* note 4; Eisenberg, *Unconventional Medicine*, *supra* note 2.

⁷⁴ See *supra* note 11 and accompanying text.

⁷⁵ See Andrews, *supra* note 9, at 1288; see also *Bowland v. Municipal Court*, 556 P.2d 1081, 1082 (Cal. 1976).

⁷⁶ See Andrews, *supra* note 9, at 1288; see also *In re Guess*, 393 S.E.2d 833, 834 (N.C. 1990); *Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 610 N.Y.S.2d 334 (3d Dep't 1994).

⁷⁷ See Andrews, *supra* note 9, at 1288; see also *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 211 (7th Cir. 1983).

⁷⁸ See Andrews, *supra* note 9, at 1288; see also *Andrews v. Ballard*, 498 F. Supp. 1038, 1039 (S.D. Tex. 1980).

⁷⁹ See Andrews, *supra* note 9, at 1288; see also *Idaho Ass'n of Naturopathic Physicians v. FDA*, 582 F.2d 849, 851 (4th Cir. 1978). Naturopathy is the use of natural foods and medicines to assist the self-healing processes of the body. *Id.* at 850.

⁸⁰ See *Wilk*, 719 F.2d at 211; see also Andrews, *supra* note 9, at 1292, 1294; *Boozang*, *supra* note 1, at 212 n.63; *Josefek*, *supra* note 9, at 310 n.166.

influence public sentiment [would] be almost unlimited, and whose requests for desirable legislation [would] everywhere be met with the respect which the politician always has for organized votes.’⁸¹ The current regulatory scheme of healthcare providers, particularly in the areas of licensing, scope of practice rules, and medical disciplinary actions, reflects the powerful influence and dominance of biomedicine.⁸² Despite the current increased interest by the biomedical community, physicians who integrate CAM into their practice remain vulnerable to the unfettered discretion of medical boards to investigate, charge, and discipline them for practices that do not conform to the acceptable and prevailing biomedical practice.⁸³

New York physicians who have been investigated by the OPMC have faced financial devastation and irreparable loss of reputation.⁸⁴ In the past decade, legislators have taken notice of the dual deprivation of the rights of patients to choose their health care and the rights of physicians to choose innovative therapies that effectively treat their patients. New York is one of the first states to enact legislation intended to protect both the rights of patients to choose and the rights of physicians to offer CAM.⁸⁵ “Ultimately, by protecting the rights of nonconventional

⁸¹ COHEN, *supra* note 17, at 19 (quoting 36 JAMA 515 (1902)).

⁸² See generally *id.* at 21–22 (discussing recent broad interpretations of the “practice of medicine”).

⁸³ See *id.* at 92–93. “The twin issues of physicians’ vulnerability and medical boards’ unfettered discretion in disciplining physicians challenge medical freedom and innovation and discourage a patient-centered approach that integrates nonbiomedical alternatives.” *Id.*

⁸⁴ Burton Goldberg, *Fight for Your Life: State Medical Boards Are Persecuting Alternative Physicians for Trying Too Hard to Cure Their Patients*, ALTERNATIVE MED., Oct. 2002, 12–14. The author recognizes that New York Doctor Serafina Corsello, a CAM physician, recently had her license revoked. As a result, it “has cost her hundreds of thousands of dollars and nearly bankrupted her.” *Id.* at 14; see also *New York City Hearings Before the White House Commission on Complementary/Alternative Medicine* (Jan. 23, 2001) (testimony of Drs. Jennifer Daniels, Serafina Corsello, and Charles Gant).

⁸⁵ There are twelve states, including New York, that have passed laws to protect the rights of nonconventional physicians as well as the right of citizens’ access to the medical care of their choice. See, e.g., ALASKA STAT. § 08.64.326(a)(8)(A) (Michie 2002); COLO. REV. STAT. § 12-36-117 (2002); FLA. STAT. ANN. § 456.41 (West 2003); GA. CODE ANN. § 43-34-42.1 (2002); MASS. GEN. LAWS ch. 112, § 7 (2002); N.Y. EDUC. LAW § 6527(4) (McKinney 2003); N.Y. PUB. HEALTH LAW §§ 230(1), 230(10)(a)(ii) (McKinney 2002); N.C. GEN. STAT. § 90-14(a)(6) (1993); OHIO REV. CODE ANN. § 4731.227 (Anderson 2001); OKLA. STAT. tit. 59, §§ 492(F), 493.1(M), 509.1 (D)(2) (2003); OR. REV. STAT. § 677.190(1) (1995); 22 TEX. ADMIN. CODE § 200.1–200.3 (West 1998); WASH. REV. CODE § 18.130.180(4) (2002).

physicians throughout the misconduct process, this legislation secures the rights and freedom of patients to choose their medical treatments.⁸⁶ The legislation provides for a disciplinary process that includes peer review by a hearing committee to determine the validity of charges and the appropriateness of sanctions.⁸⁷ Additionally, to ensure “that a physician charged with misconduct receives fair consideration by those best qualified to judge his or her practice and methods of treatment,”⁸⁸ the sponsors provided that the hearing committee should consist of two physicians and one layperson.⁸⁹

However, in the case of a physician who practices nonconventional medicine—i.e., treatments which differ from customary or prevailing approaches, such as homeopathy, chelation therapy, herbal medicine and vitamin therapy—the review process established in [the] statute may not always provide for a fair and impartial hearing. Since there are no nonconventional physicians who serve on the board for professional medical conduct, no legitimate peer review exists when issues involve clinical practice that is foreign, innovative, or has been shown to be effective[,] but has not yet achieved general acceptance in the United States. Rather, according to the community of nonconventional physicians, they are judged prejudicially by orthodox doctors who discount their treatments and medical doctrines, and often impose upon them penalties more severe than those assessed against conventional physicians found guilty of equivalent misconduct charges. Consequently, there is legitimate concern among practitioners of nonconventional medicine that the existing professional medical conduct process does not conform to case law which has affirmed the rights of patients to choose such treatments.⁹⁰

Both houses of the New York State Legislature intended the act to address “the potential for abuse [that] exists in a peer review system that does not have any peers”⁹¹ by assuring that

⁸⁶ Memorandum from New York Senator Holland in Support of S.3636-2 (July 20, 1994) [hereinafter Holland Memo] (stating that “this legislation is designed to safeguard patients’ rights and guarantee legitimate due process for nonconventional physicians”). See generally Memorandum from New York Assemblyman Colman in Support of A.5411-C (July 18, 1994) [hereinafter Colman Memo].

⁸⁷ Holland Memo, *supra* note 86.

⁸⁸ Colman Memo, *supra* note 86, at 1.

⁸⁹ Holland Memo, *supra* note 86.

⁹⁰ Colman Memo, *supra* note 86, at 1–2.

⁹¹ Holland Memo, *supra* note 86.

there would be constructive participation by nonconventional physicians in the investigation and disposition of medical misconduct charges against the nonconventional physician under review.⁹²

Despite the good intentions of New York legislators, neither the New York State Board for Professional Medical Conduct (BPMC), which includes the actions of OPMC, nor the New York courts have provided adequate safeguards and rights to CAM physicians and patients.

A. *Disciplinary Procedures*

The Fourteenth Amendment of the United States Constitution provides that “no state shall deprive any person of life, liberty, or property, without due process of law.”⁹³ Although states have the police power to regulate the practice of medicine, a license to practice medicine may only be denied or withdrawn in accordance with procedures required by constitutional due process.⁹⁴ Due process requires that statutes and regulations to provide adequate notice of illegal conduct in order to enable individuals to conform their behavior to the law.⁹⁵ Most states delineate acts of professional misconduct that subject physicians to sanctions for their violation.⁹⁶ New York is no exception. New York Education Law enumerates forty-seven acts of professional misconduct.⁹⁷ Professional misconduct for physicians include:

⁹² *Id.*

⁹³ U.S. CONST. amend. XIV, § 1.

⁹⁴ *Doe v. Axelrod*, 123 A.D.2d 21, 26, 510 N.Y.S.2d 92, 95 (1st Dep’t 1986) (“A license to practice medicine is a valuable property right which, although subject to regulation under the state’s police power, may only be denied or withdrawn under procedures consonant with constitutional due process.”); *see also Keney v. Derbyshire*, 718 F.2d 352, 354 (10th Cir. 1983) (citing *Greene v. McElroy*, 360 U.S. 474, 492 (1959)). The procedures used by the medical board in *Keney* included “prior notice, a formal hearing, right to counsel, prehearing discovery, affirmative case presentation, witness cross-examination, and employment of rules of evidence.” *Id.* at 355.

⁹⁵ *Binenfeld v. N.Y. State Dep’t of Health*, 226 A.D.2d 935, 936, 640 N.Y.S.2d 924, 925 (3d Dep’t 1996) (“It is a basic principle of due process that statutes and regulations must give persons of ordinary intelligence a reasonable opportunity to know what is prohibited so that they may act accordingly.”).

⁹⁶ *See, e.g., N.Y. EDUC. LAW §§ 6530, 6531* (McKinney 2001), N.C. GEN. STAT. § 90-14(a)(6) (1993); *see also supra* note 42.

⁹⁷ *Binenfeld*, 226 A.D.2d at 936, 640 N.Y.S.2d at 925–26; N.Y. EDUC. LAW § 6530 (McKinney 2001).

1. Obtaining [a medical] license fraudulently; 2. Practicing the profession fraudulently or beyond its authorized scope; 3. Practicing the profession with negligence on more than one occasion; 4. Practicing the profession with gross negligence on a particular occasion; 5. Practicing the profession with incompetence on more than one occasion; 6. Practicing the profession with gross incompetence; 7. Practicing the profession while impaired by alcohol, [of] drugs . . . ; 9. (a) Being convicted of committing an act constituting a crime⁹⁸

Pursuant to Public Health Law section 230, the BPMC was created to investigate and impose discipline for professional misconduct as enumerated in New York Education Law sections 6530 and 6531.⁹⁹ The BPMC, through the OPMC, is permitted to initiate an investigation but is required to “investigate each complaint received regardless of the source.”¹⁰⁰ The OPMC director is required to review a preliminary report to determine if it “reasonably appears to reflect physician conduct warranting further investigation.”¹⁰¹ In the event that a reviewed case which is referred to an investigation committee involves issues of clinical practice, medical experts, including experts “dedicated to the advancement of nonconventional medical treatments,” are to be consulted.¹⁰²

When a preliminarily investigated case is referred to an investigation committee, the targeted physician may obtain a personal interview before the OPMC to explain the issues being investigated.¹⁰³ The opportunity for such an interview is a prerequisite to the convening of a BPMC investigation committee.¹⁰⁴ The director of OPMC must obtain “the concurrence of a majority of an investigation committee” before ultimately deciding that a hearing is warranted.¹⁰⁵

If the director determines after consultation with an investigation committee that: (A) evidence exists of a single incident of negligence or incompetence . . . ; (B) a recommendation was made by a county medical society or the

⁹⁸ N.Y. EDUC. LAW § 6530 (McKinney 2001).

⁹⁹ N.Y. PUB. HEALTH LAW § 230(1) (McKinney 2001).

¹⁰⁰ *Id.* § 230(10)(a)(i).

¹⁰¹ *Id.*

¹⁰² *Id.* § 230(10)(a)(ii).

¹⁰³ *Id.* § 230(10)(a)(iii).

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* § 230(10)(a)(iv).

medical society of the [s]tate of New York that warrants further review; . . . the director . . . shall be authorized to conduct a comprehensive review of patient records of the licensee and such office records of the licensee as are related to said determination.¹⁰⁶

The charges must state "clearly and concisely the material facts" underlying the complaint.¹⁰⁷ The physician is entitled to service of the charges and notice of the hearing.¹⁰⁸ The hearing is conducted by a three-member hearing committee that consists of two physicians and one lay person.¹⁰⁹ A request may be made to the ARB to review the hearing committee's determination.¹¹⁰

The physician under review may also appeal the hearing committee's determination to the Appellate Division, Third Department.¹¹¹ However, the "standard of review . . . is stringent."¹¹² The appellate division will only consider whether the determination "was made in violation of lawful procedure, was affected by an error of law, was arbitrary and capricious or was an abuse of discretion."¹¹³ If the physician is found guilty of professional misconduct, the penalties that may be imposed include suspension, revocation, or fine.¹¹⁴ In appropriate circumstances, a physician may be required to receive further education or perform community service.¹¹⁵ New York courts have held that the penalty imposed is not intended to punish the physician, but rather to protect the public health and welfare.¹¹⁶

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* § 230(10)(b).

¹⁰⁸ *Id.* § 230(10)(c), (d).

¹⁰⁹ *Id.* § 230(6).

¹¹⁰ *Id.* § 230(1)(i).

¹¹¹ *Id.* § 239(c)(5). All such appeals are submitted only to the Appellate Division, Third Department.

¹¹² *Gonzalez v. N.Y. State Dep't of Health*, 232 A.D.2d 886, 889, 648 N.Y.S.2d 827, 831 (3d Dep't 1996).

¹¹³ *Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.2d 334, 336 (3d Dep't 1994); *see Bogdan v. N.Y. Bd. for Prof'l Med. Conduct*, 195 A.D.2d 86, 606 N.Y.S.2d 381 (3d Dep't 1993).

¹¹⁴ N.Y. PUB. HEALTH LAW § 230(a)(1), (2), (4), (7) (McKinney 1996).

¹¹⁵ *Id.* § 230(a)(8), (9).

¹¹⁶ *See Hawker v. New York*, 170 U.S. 189, 199 (1898) (regarding a medical disciplinary matter); *Bell v. Bd. of Regents of Univ. of N.Y.*, 295 N.Y. 101, 109; 65 N.E.2d 184, 188 (1945); *Matter of Cowan*, 110 A.D.2d 53, 56, 493 N.Y.S.2d 7, 10 (1st Dep't 1985) (regarding a lawyer disciplinary matter); *see also Colo. State Bd. of Med. Exam'r v. Reiner*, 786 P.2d 499, 500 (Colo. Ct. App. 1989).

1. Procedural Issues

The BMPC is required to investigate every complaint that it receives.¹¹⁷ The power of the BMPC to investigate, however, is not limited to a single complaint received.¹¹⁸ It has such wide latitude that it may extend the investigation beyond the facts and specifics of the initial complaint.¹¹⁹ This means that, hypothetically, if a conventional physician makes a complaint to the BMPC that alleges Dr. A is using nutrients to treat patient Y's illness, the BMPC has the discretion to investigate any of Dr. A's patients. Additionally, the BMPC may investigate Dr. A's general medical practice, including such matters as the frequency of follow-up visits and general monitoring, billing procedures, and patient record keeping, to determine if there are any variations from the standard conventional medical care.¹²⁰ In this context, it is worth noting that these complaints need not be—and in the case of CAM physicians typically are not—from the patient but from other physicians.¹²¹

Following the concurrence of a majority of the investigation committee and consultation with the executive director of the BPMC, the OPMC director may determine that a hearing is warranted and direct that charges be prepared.¹²²

In a typical case, the OPMC requests that the physician provide specific records. Most often the request is for a particular patient's file.¹²³ Even if the physician cooperates by providing the requested documents, the OPMC is authorized to conduct a comprehensive medical review (CMR).¹²⁴ At this point,

¹¹⁷ See *supra* note 100 and accompanying text.

¹¹⁸ See *supra* note 102 and accompanying text; see also *Alter v. N.Y. Dep't of Health, State Bd. for Prof'l Med. Conduct*, 145 Misc.2d 393, 395, 546 N.Y.S.2d 746, 748 (Sup. Ct. N.Y. County 1989).

¹¹⁹ See *Alter*, 145 Misc. 2d at 395, 546 N.Y.S.2d at 748.

¹²⁰ See, e.g., *Gonzalez v. N.Y. State Dep't of Health*, 232 A.D.2d 866, 648 N.Y.S.2d 827 (3d Dep't 1996); *Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 610 N.Y.S.2d 334 (3d Dep't 1994); *Alter*, 145 Misc.2d at 395, 546 N.Y.S.2d at 748. Theoretically, the BMPC may investigate for any statutorily defined medical misconduct. See *supra* notes 93–95 and accompanying text.

¹²¹ See *Studdert*, *supra* note 5, at 1610. The authors reviewed malpractice claims against CAM practitioners other than physicians and concluded that the claims against CAM practitioners were relatively infrequent and of less severity.

¹²² See *supra* note 105 and accompanying text.

¹²³ See *Alter*, 145 Misc.2d at 395, 546 N.Y.S.2d at 748; *Dombroff v. State Bd. for Prof'l Med. Conduct*, 131 Misc.2d 472, 473, 500 N.Y.S.2d 617, 618 (Sup. Ct. N.Y. County 1986).

¹²⁴ See *supra* notes 102–03 and accompanying text. The director of the OPMC is

the OPMC may order the physician to provide the patient's files and office records beyond the specifics of the original complaint.¹²⁵ If the physician refuses to produce the requested documents, the OPMC may seek an order by a New York State Supreme Court justice to compel compliance.¹²⁶

The court shall not grant the application unless it finds that (i) there was a reasonable basis for issuance of the director's order and (ii) there is reasonable cause to believe that the records sought are relevant to the director's order. The court may deny the application or grant the application in whole or in part.¹²⁷

In alternative to an order by the OPMC pursuant to Public Health Law section 230(10)(o) to produce certain documents, a subpoena for those documents may be served upon the physician.¹²⁸ Prior to the issuance of a *subpoena duces tecum*, the executive secretary of the BPMC must obtain approval¹²⁹ from a committee of two physicians and one lay person.¹³⁰ The legislative mandate that requires prior approval for any subpoena provides additional protection to physicians and others who are the subject of the subpoena.¹³¹ This is "a check 'not provided in the legislation creating many administrative agencies.'"¹³² Due to limits on the scope of administrative investigations, the physician may move, before a New York Supreme Court justice, pursuant to CPLR section 2304, to quash the subpoena based upon the appropriateness of the investigation.¹³³

authorized to conduct a comprehensive review if, after consultation with an investigation committee, it is determined that certain statutory conditions exist.

¹²⁵ See *supra* notes 119-20 and accompanying text; see also *Alter*, 145 Misc.2d at 395, 546 N.Y.S.2d at 748; *Dombroff*, 131 Misc.2d at 473, 500 N.Y.S.2d at 618.

¹²⁶ N.Y. PUB. HEALTH LAW § 230(10)(o) (McKinney 1996).

¹²⁷ *Id.*

¹²⁸ *Id.* § 230(10)(k)(l). In order to issue the subpoena, the executive secretary of the BPMC must obtain the prior approval of a BPMC committee on professional conduct. *Id.*; see *Shankman v. Axelrod*, 73 N.Y.2d 203, 205, 535 N.E.2d 1323, 1324, 538 N.Y.S.2d 783, 784 (1989); *Dombroff*, 131 Misc.2d at 474, 500 N.Y.S.2d at 619.

¹²⁹ N.Y. PUB. HEALTH LAW § 230(6) (McKinney 1996).

¹³⁰ *Id.* § 230(10)(k); see also *Shankman*, 73 N.Y.2d at 205, 535 N.E.2d at 1324, 538 N.Y.S.2d at 784.

¹³¹ See *Dombroff*, 131 Misc.2d at 474, 500 N.Y.S.2d at 619.

¹³² *Id.*, 500 N.Y.S.2d at 619 (quoting *Levin v. Murawski*, 59 N.Y.2d 35, 47, 449 N.E.2d 730, 737, 462 N.Y.S.2d 836, 842 (1983) (Simons, J., dissenting)).

¹³³ *Levin v. Murawski*, 59 N.Y.2d 35, 38, 449 N.E.2d 730, 731, 462 N.Y.S.2d 836, 837 (1983).

The state legislature cannot “confer upon an executive an arbitrary and unbridled discretion as to the scope of his investigation.”¹³⁴ “It is ancient law that no agency of government may conduct an unlimited and general inquisition into the affairs of persons within its jurisdiction solely on the prospect of possible violations of law being discovered, especially with respect to *subpoenas duces tecum*.”¹³⁵ A motion to quash a *subpoena duces tecum* issued by the BPMC requires that the BPMC demonstrate to the court that there is “a showing that there exists ‘some basis for inquisitorial action’” or, more specifically, “a threshold showing of the authenticity of the complaint as warranting investigation.”¹³⁶ Moreover, the documents that the government agency seeks to obtain must “have some relevancy and materiality to the matter under investigation.”¹³⁷ The requirement for a “minimum threshold foundation” to support the BPMC’s issuance of a subpoena will vary from case to case.¹³⁸

There is, however, a basic “requirement that there be prima facie proof of a justifiable basis for a good faith investigation of professional misconduct.”¹³⁹ The bona fide authenticity of the complaint and subsequent investigation

may relate to the reliability of the complainant; it may be shown by the substance of the complaint. Specific detail as to identification of the complainant, some evidence of his good faith or reliability, disclosure of the basis for his knowledge of the substance of the complaint, with dates to establish its currency, and some revelation of the substance of the complaint

¹³⁴ *Carlisle v. Bennett*, 268 N.Y. 212, 217, 197 N.E. 220, 222 (1935); see also *A’Hearn v. Comm. on Unlawful Practice of Law of N.Y. County Lawyers’ Ass’n*, 23 N.Y.2d 916, 918, 246 N.E.2d 166, 167, 298 N.Y.S.2d 315, 316 (1969); *La Belle Creole Int’l v. Att’y-Gen. of N.Y.*, 10 N.Y.2d 192, 196, 176 N.E.2d 705, 707, 219 N.Y.S.2d 1, 4 (1961).

¹³⁵ *A’Hearn*, 23 N.Y.2d at 918, 246 N.E.2d at 167, 298 N.Y.S.2d at 316 (citations omitted); see also *Murawski*, 59 N.Y.S.2d at 41, 449 N.E.2d at 733, 462 N.Y.S.2d at 839.

¹³⁶ *Murawski*, 59 N.Y.2d at 41, 449 N.E.2d at 733, 462 N.Y.S.2d at 839.

¹³⁷ *Carlisle*, 268 N.Y. at 218, 197 N.E. at 222; see also *Murawski*, 59 N.Y.2d at 40–41, 449 N.E.2d at 732–33, 462 N.Y.S.2d at 838–39.

¹³⁸ *Murawski*, 59 N.Y.2d at 40, 449 N.E.2d at 732, 462 N.Y.S.2d at 838.

¹³⁹ *Id.* at 41, 449 N.E.2d at 733, 462 N.Y.S.2d at 839; see also *Matter of BU 91-04-1356A*, 186 A.D.2d 1054, 1054, 588 N.Y.S.2d 954, 954 (4th Dep’t 1992); *Matter of BU 90-09-2400*, 184 A.D.2d 1028, 1029, 584 N.Y.S.2d 696, 697 (4th Dep’t 1992).

will normally suffice, but all or most of this data may not be necessary.¹⁴⁰

"Sufficient authenticating detail may be found in the complaint itself; if not, it must be independently supplied."¹⁴¹ The BPMC must provide written notice to the physician of an application pursuant to Public Health Law section 230(10)(o).¹⁴² The good faith requirement in support of that application or the BPMC's request to compel compliance with a *subpoena duces tecum* may be submitted for an in camera court review. This review assesses whether the complaint is authentic and of sufficient substance to warrant an investigation.¹⁴³ If the

¹⁴⁰ *Murawski*, 59 N.Y.2d at 42, 449 N.E.2d at 733-34, 462 N.Y.S.2d at 839-40. The court in *Murawski* footnoted here that "[i]f the issuing agency demonstrates the delicacy of a particular investigation or the risk of and consequences attendant on premature disclosure, it may be appropriate to take proof of the threshold foundation *in camera*." *Id.* at 42 n.4, 449 N.E.2d at 734 n.4, 462 N.Y.S.2d at 840 n.4 (quoting *Matter of Sussman v. N.Y. State Organized Crime Task Force*, 39 N.Y.2d 227, 233, 347 N.E.2d 638, 642, 383 N.Y.S.2d 276, 280 (1976)). *Sussman* involved a multi-county investigation into organized crime activities. The supreme court attempted to balance the interests of the attorney general to engage in difficult and sensitive investigations with "the interests of witnesses in their legitimate protection." *Sussman*, 39 N.Y.2d at 232, 347 N.E.2d at 641, 383 N.Y.S.2d at 279. Because of this balancing of interests, the *Sussman* court observed "that there may be instances, perhaps few in number, in which the delicacy of the particular investigation or the risk of and consequences attendant on premature disclosure may be such that it will be appropriate to employ specially limited, *in camera* . . . procedures in which to receive the Deputy Attorney-General's proof." *Id.* at 233, 347 N.E.2d at 642, 383 N.Y.S.2d at 280.

¹⁴¹ *Murawski*, 59 N.Y.2d at 42, 449 N.E.2d at 734, 462 N.Y.S.2d at 840.

¹⁴² See *Shankman v. Axelrod*, 73 N.Y.2d 203, 206-07, 535 N.E.2d 1323, 1324-25, 538 N.Y.S.2d 783, 784-85 (1989); *Tanner v. Dr. A.*, 228 A.D.2d 238, 239, 644 N.Y.S.2d 20, 21 (1st Dep't 1996); *Lepley v. Health Office of Prof'l Med. Conduct*, 190 A.D.2d 556, 557, 593 N.Y.S.2d 235, 236 (1st Dep't 1993).

¹⁴³ *Murawski*, 59 N.Y.2d at 41-42, 449 N.E.2d at 733, 462 N.Y.S.2d at 839; see *Tanner*, 228 A.D.2d at 239, 644 N.Y.S.2d at 21; *Lepley*, 190 A.D.2d at 557, 593 N.Y.S.2d at 236; *Alter v. N.Y. State Dep't of Health, State Bd. for Prof'l Med. Conduct*, 145 Misc. 2d 393, 395, 546 N.Y.S.2d 746, 748 (Sup. Ct. N.Y. County 1989); *Dombroff v. State Bd. for Prof'l Med. Conduct*, 131 Misc. 2d 472, 474, 500 N.Y.S.2d 617, 619 (Sup. Ct. N.Y. County 1986); see also *Atkins v. Guest*, 158 Misc. 2d 426, 430-31, 601 N.Y.S.2d 234, 237-38 (Sup. Ct. N.Y. County 1993). The courts routine use of in camera reviews of the BPMC's good-faith requirement in their investigations of physicians appears inconsistent with the Court of Appeals observation in *Murawski* and *Sussman* that there may be instances, even if only a few, that necessitate an in camera review. These cases do not indicate whether the investigations were delicate or if there were any risks related to premature disclosure. At the time the Court of Appeals decided *Murawski*, the court was fully aware of the confidentiality requirements of Public Health Law section 230(a)(ii). The court, however, did not require that all such applications be reviewed in camera. See *Murawski*, 59 N.Y.2d at 41, 449 N.E.2d at 733, 462 N.Y.S.2d at 839.

authenticity of the complaint has not been demonstrated by the BPMC, the *subpoena duces tecum* will be quashed.¹⁴⁴ In that circumstance, the court need not decide whether the subpoenaed materials were relevant to the investigation.¹⁴⁵

In the event that the court orders the physician to comply with the OPMC's order¹⁴⁶ or with a *subpoena duces tecum*, the physician is obligated to provide the requested documents.¹⁴⁷ The failure to provide the documents, to permit a CMR, or otherwise to cooperate with the investigation may result in the suspension of the physician's license.¹⁴⁸

2. Fairness and Equity

The Alternative Medical Practice Act (AMPA) was enacted in 1994 in part to ensure fairness for nonconventional physicians in a peer review disciplinary system. Prior to the legislation there were no nonconventional peers in the system available to

Additionally, the targeted physician should be permitted to be aware of the basis for the BPMC's request for secrecy and be given the opportunity to respond. In *Atkins*, the name of the complainant, an emergency room doctor, and the patient were known to the physician and the general public. *Atkins*, 158 Misc. 2d at 430–31, 601 N.Y.S.2d at 237–38. Despite this, the court still held that an in camera court review was required. *Id.* at 431–32, 601 N.Y.S.2d at 238–39. The court maintained that even though the patient's and complainant's names were known, it did "not justify the public release of the Patient's hospital records, the complaint by the complaining doctor or a laundry list of treatments the Patient received." *Id.* at 431, 601 N.Y.S.2d at 238.

¹⁴⁴ See *Murawski*, 59 N.Y.2d at 42, 449 N.E.2d at 734, 462 N.Y.S.2d at 840.

¹⁴⁵ See *id.*, 449 N.E.2d at 734, 462 N.Y.S.2d at 840. The court noted that it would be inappropriate to consider the issue of relevancy because, in part, it would require an examination of the statutory language contained in the Public Health Law section 230(10)(k) that authorizes the issuance of a subpoena "with reference to a matter within the scope of the inquiry or the investigation being conducted by the board." *Id.* at 39 n.1, 449 N.E.2d at 732 n.1, 462 N.Y.S.2d at 838 n.1. A review of the reported cases did not reveal any case that examined the meaning to be given to the "scope of the inquiry or the investigation." *Id.* at 43, 449 N.E.2d at 734, 462 N.Y.S.2d at 840.

¹⁴⁶ See N.Y. PUB. HEALTH LAW § 230(10)(o) (McKinney 1991); see also *supra* notes 124–26 and accompanying text.

¹⁴⁷ Of course, the physician does have the right to appeal the order to the appellate division. See, e.g., *Murawski*, 59 N.Y.2d at 38, 449 N.E.2d at 731, 462 N.Y.S.2d at 837; *Tanner*, 228 A.D.2d at 239, 644 N.Y.S.2d at 21 (physician appealed a ruling from the supreme court to the appellate division); *Atkins*, 158 Misc. 2d at 428, 601 N.Y.S.2d at 236 (physician appealed to the supreme court to quash the subpoena duces tecum); *Alter*, 145 Misc. 2d at 394, 546 N.Y.S.2d at 747 (physician appealed to the supreme court to quash the subpoena duces tecum).

¹⁴⁸ See N.Y. PUB. HEALTH LAW § 230(10)(a)(4) (McKinney 1991).

complete the review.¹⁴⁹ The AMPA added two nonconventional physicians to the BPMC¹⁵⁰ to guarantee that a nonconventional "physician charged with misconduct receives fair consideration by those best qualified to judge his or her practice and methods of treatment."¹⁵¹ This guarantee of fair consideration was to be achieved by the constructive participation of the nonconventional physicians "in the investigation and disposition of misconduct cases involving issues of clinical practice."¹⁵² To implement the legislative intent, a nonconventional physician should be appointed to the investigation committee or the hearing committee or the administrative review board (ARB), or all of these groups. Constructive participation could be achieved by requiring consultation with a nonconventional medical expert where issues of clinical practice are involved.¹⁵³ The New York courts, however, have not required any participation by the nonconventional physicians on the BPMC investigation or hearing committees or on the ARB.¹⁵⁴ It is less clear whether the New York courts will require nonconventional medical experts in cases implicating clinical practice issues to participate in the activities of these groups.

In three cases decided prior to the 1994 enactment of the AMPA, physicians raised the statutory requirement to consult nonconventional medical physicians. In two of those cases, osteopathic physicians claimed that the statute required that an osteopath be a member of the hearing committee.¹⁵⁵ In

¹⁴⁹ See Holland Memo, *supra* note 86 and accompanying text; Colman Memo, *supra* note 86 and accompanying text.

¹⁵⁰ The number of physicians on the BPMC was an apparent compromise. The senate sponsor sought the addition of three nonconventional physicians to the BPMC. See Holland Memo, *supra* note 86.

¹⁵¹ See Holland Memo, *supra* note 86.

¹⁵² See *supra* note 151.

¹⁵³ See N.Y. PUB. HEALTH LAW § 230(10)(a)(ii) (McKinney 1991). The nonconventional medical "[e]xperts may be made available by . . . New York state medical associations dedicated to the advancement of nonconventional medical treatments." *Id.*

¹⁵⁴ See, e.g., *Gonzalez v. N.Y. State Dep't of Health*, 232 A.D.2d 886, 888, 648 N.Y.S.2d 827, 830 (3d Dep't 1996); *Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.2d 334, 336 (3d Dep't 1994).

¹⁵⁵ See *Amarnick v. Sobol*, 173 A.D.2d 914, 916, 569 N.Y.S.2d 780, 782 (3d Dep't 1991); *Rosenberg v. Bd. of Regents of the Univ. of N.Y.*, 96 A.D.2d 651, 652, 466 N.Y.S.2d 743, 745 (3d Dep't 1983). An osteopath is a doctor who treats osteopathy, a "disease of [the] bone." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1597 (3d ed. 1993).

Rosenberg v. Board of Regents of the University of New York,¹⁵⁶ the osteopath argued that “his constitutional rights to equal protection and due process of law were violated because no osteopath served on the hearing panel.”¹⁵⁷ In *Amarnick v. Sobel*,¹⁵⁸ the osteopath asserted that he “did not receive a fair hearing before an unbiased panel.”¹⁵⁹ In both cases, the Appellate Division, Third Department, held that the “Public Health Law § 230(6) does not . . . require the hearing committee to have a physician on the panel who specializes in the charged physician’s area of expertise.”¹⁶⁰ The third case involved a physician who practiced homeopathy.¹⁶¹ In *Metzler*, the physician contended that the findings of the hearing committee and the ARB were “the result of a bias against homeopathy.”¹⁶² After finding that the physician failed to provide any persuasive evidence of bias, the court further found “that there is no requirement that members of the [c]ommittee or the [r]eview [b]oard be practitioners of the same specialty as the physician under review, much less that they be adherents to the same philosophy of medicine.”¹⁶³

Finally, in *Gonzalez*,¹⁶⁴ a case decided after the AMPA was passed, a physician who specialized in nutritional therapy to treat advanced and incurable cancer patients, argued that the AMPA mandated “that he [was] entitled to a new hearing before a [h]earing [c]ommittee which consists of at least one nonconventional physician.”¹⁶⁵ In dicta, the Appellate Division, Third Department stated that “the legislation does not guarantee petitioner, as a nonconventional physician, that a nonconventional physician will be on the [h]earing [c]ommittee

¹⁵⁶ 96 A.D.2d 651, 466 N.Y.S.2d 743 (3d Dep’t 1983).

¹⁵⁷ *Rosenberg*, 96 A.D.2d at 652, 466 N.Y.S.2d at 745.

¹⁵⁸ 173 A.D.2d 914, 569 N.Y.S.2d 780 (3d Dep’t 1991).

¹⁵⁹ *Amarnick*, 173 A.D.2d at 916, 569 N.Y.S.2d at 782.

¹⁶⁰ *Id.*, 569 N.Y.S.2d at 782 (citing *Rosenberg*, 96 A.D.2d at 652, 466 N.Y.S.2d at 745).

¹⁶¹ See *Metzler*, 203 A.D.2d at 617, 610 N.Y.S.2d at 335; *supra* notes 32–38 and accompanying text.

¹⁶² *Metzler*, 203 A.D.2d at 619, 610 N.Y.S.2d at 336.

¹⁶³ *Id.*, 610 N.Y.S.2d at 336. The court cited to its previous decisions in *Rosenberg* and *Amarnick*. See *id.*, 610 N.Y.S.2d at 336.

¹⁶⁴ See *Gonzalez v. N.Y. State Dep’t of Health*, 232 A.D.2d 886, 648 N.Y.S.2d 827 (3d Dep’t 1996); *supra* notes 47–54 and accompanying text.

¹⁶⁵ *Gonzalez*, 232 A.D.2d at 887, 648 N.Y.S.2d at 830.

which determines his case.”¹⁶⁶ The court noted that all the law required was that there be at least two nonconventional physicians among the eighteen physicians on the BMPC.¹⁶⁷

Public Health Law section 230(1) does not mandate that there be nonconventional physician representation on the particular hearing committee reviewing the charges against a nonconventional physician. The legislative intent, however, is to promote “greater participation by nonconventional physicians in the investigation and disposition of misconduct cases involving issues of clinical practice.”¹⁶⁸ Nonconventional physicians and the public commonly perceive that nonconventional physicians are judged prejudicially.¹⁶⁹ This perception will continue unless either a nonconventional physician BMPC member constructively participates in the particular investigation or hearing committee or both, or a peer medical expert is consulted. Despite the clear legislative intent, New York physicians continue to be subjected to a process that denies them “fair consideration by those best qualified to judge [their] practice and methods of treatment.”¹⁷⁰ The following discussion of the cases of two physicians who are currently undergoing the disciplinary process illustrates the lack of a legitimate peer review process.

¹⁶⁶ *Id.* at 888, 648 N.Y.S.2d at 830. The physicians’ hearing was completed on March 8, 1994 and the hearing committee’s decision was effective on June 8, 1994. Because the AMPA was effective as of July 26, 1994, the court concluded that “in the absence of any indication of legislative intent to provide retroactivity . . . the legislation should only be applied prospectively.” *Id.*, 648 N.Y.S.2d at 830.

¹⁶⁷ *Id.*, 648 N.Y.S.2d at 830.

¹⁶⁸ Colman Memo, *supra* note 86, at 1 (supporting the AMPA).

¹⁶⁹ *See, e.g.,* Goldberg, *supra* note 84, at 12. “While the public clamors for more access to alternative medical therapies, alternative physicians are still being singled out by state medical boards. New York might be the worst offender.” *New York City Hearings Before the White House Commission on Complementary/Alternative Medicine* (Jan. 23, 2001) (testimonies of Drs. Daniels, Corsello, and Gant, and Arnold Gold); *see also* Holland Memo, *supra* note 86; Colman Memo, *supra* note 86. The legislative memoranda clearly expressed the intent to reduce, if not eliminate, the potential abuse in the disciplinary process in order to protect patients’ rights to access CAM therapies, and nonconventional physicians would receive legitimate due process. *See also* COHEN, TOWNSEND LETTER FOR DOCTORS AND PATIENTS, Part One: Introduction, Aug.–Sept., 2001, Part Two: Complementary and Alternative Physicians, Oct., 2001, Part Three: Medical Policies and the Reform of the OPMC, Jan., 2002, Part Four: Reforming New York’s OPMC: Curative or Cosmetic Surgery?, July, 2002; A CONSUMER FOR MEDICAL CHOICE REPORT, THE WAR AGAINST ALTERNATIVE MEDICINE: HOW MAINSTREAM MEDICINE IS TRYING TO DESTROY COMPLEMENTARY AND ALTERNATIVE MEDICINE (Quicksilver Press 2002).

¹⁷⁰ *See* Holland Memo, *supra* note 86; Colman Memo, *supra* note 86; *see also* Cohen, *supra* note 169.

Dr. Serafina Corsello was charged with gross negligence and gross incompetence¹⁷¹ for ordering inappropriate and excessive medical testing and treatment.¹⁷² In Dr. Corsello's case, the OPMC consulted a conventional physician expert to review the facts in support of the complaint. "The expert . . . stated in his written report that he ha[d] virtually no knowledge about alternative medicine, and despite extensive efforts, including seeking judicial intervention before a New York supreme court justice, Dr. Corsello has not had an alternative medical provider review her records for investigative purposes."¹⁷³

In another recent case, Dr. Jennifer Daniels's license to practice medicine was indefinitely suspended based on her unwillingness to allow a comprehensive medical review under Public Health Law section 230(10), in violation of N.Y Education Law section 6530(15).¹⁷⁴ Initially, Dr. Daniels's was served with a request to provide a particular patient's records. Apparently, the diabetic patient had disregarded Dr. Daniels' treatment advice by engaging in a one-week alcohol drinking binge. As a result, the patient required emergency hospital care.¹⁷⁵ Dr. Daniels fully complied with the patient's record request and additionally provided written statements from other physicians who had reviewed the patient's records. These physicians opined that the treatment of this patient was in compliance with standard conventional practices.¹⁷⁶

¹⁷¹ See Corsello Briefs and Fact Sheet (on file with author). Dr. Corsello has practiced CAM for more than thirty-five years. She is the co-founder of the Foundation for the Advancement of Innovative Medicine. She was also one of the twenty-five physicians chosen by the National Institutes of Health to participate in the formation of the Office of Alternative Medicine, currently NCCAM. See *supra* note 7; see also Goldberg, *supra* note 84.

¹⁷² See Corsello Briefs and Fact Sheet, *supra* note 171.

¹⁷³ Corsello Brief 11 (Jan. 13, 2002) (on file with author). It was argued that the refusal of the NYS Department of Health to implement Public Health Law section 230(10)(a)(ii) "exhibited a pattern of bias and a refusal to give a fair hearing to an alternative medical provider." *Id.*

¹⁷⁴ See Briefs of Dr. Daniels and Counsel for the Bureau of Professional Medical Conduct Submitted to the ARB (on file with author).

¹⁷⁵ Although complaints are confidential pursuant to Public Health Law section 230(10)(a), it is reasonable to assume that an emergency room physician filed the complaint with the OPMC.

¹⁷⁶ Dr. Daniels practice mostly consists of conventional medicine. However, when appropriate she integrates nutritional supplements into the prevailing and acceptable medical practice. The OPMC alleged that Dr. Daniels was incompetent in her treatment of this one patient who was recently diagnosed with diabetes.

Dr. Daniels's experience evidences several procedural irregularities that lend credence to CAM physicians' perception of prejudicial treatment by the BPMC. Public Health Law section 230(10)(o)¹⁷⁷ and several New York court decisions require that there be a reasonable basis for conducting a comprehensive review of patients' records and office records.¹⁷⁸ The extent of the actual investigation of Dr. Daniels's conduct by the OPMC is unclear. It seems that an interview of the patient, and perhaps the hospital emergency room records, would have revealed the patient's gross deviation from the prescribed treatment plan. A review of the same information by a medical expert would also have revealed that the patient's medical emergency was attributable to the patient's alcohol binging rather than the addition of nutritional supplements to the patient's treatment plan.¹⁷⁹ Lastly, the CMR was based upon a single complaint of alleged incompetence. Although Public

¹⁷⁷ New York Public Health Law states:

Where the director has issued an order for a comprehensive medical review of patient records and office records pursuant to subparagraph four of paragraph (a) of this subdivision and the licensee has refused to comply with the director's order, the director may apply to a justice of the supreme court, in writing, on notice to the licensee, for a court order to compel compliance with the director's order. The court shall not grant the application unless it finds that (i) there was a reasonable basis for issuance of the director's order and (ii) there is reasonable cause to believe that the records sought are relevant to the director's order.

N.Y. PUB. HEALTH LAW § 230(10)(o).

In the event that the physician is served with a subpoena duces tecum for patients' and office records, *Murawski* requires that there be a preliminary showing of justifiable basis for a good-faith investigation as a prerequisite to the issuance of subpoenas by the BPMC. *See supra* notes 132-42 and accompanying text. Dr. Daniels's procedural history does not fit into either Public Health Law section 230(10)(o) or *Murawski*. Subsequent to receipt of the director's order for a CMR, Dr. Daniels' attorney erroneously brought an Article 78 proceeding to declare the method of conducting a CMR as illegal. The BPMC cross moved for an order to compel compliance pursuant to Public Health Law section 230(10)(o). The supreme court justice ruled that the Article 78 proceeding was time barred by the statute of limitation and thereby granted the cross motion. *Daniels v. Office of Prof'l Med. Count* (Sup. Ct. Onondaga County Jan. 9, 2001) (J. Murphy) (unpublished decision, on file with author).

¹⁷⁸ *See Tanner v. Dr. A.*, 228 A.D.2d 238, 239, 644 N.Y.S.2d 20, 21 (1st Dep't 1996); *Alter v. N.Y. State Bd. for Prof'l Conduct*, 145 Misc.2d 393, 395, 546 N.Y.S.2d 746, 748 (Sup. Ct. N.Y. County 1989).

¹⁷⁹ It is unclear whether OPMC consulted a medical expert and, if so, what the nature of the report was. Dr. Daniels, however, did submit statements by conventional physicians who did evaluate her treatment plan for the patient. *See supra* note 174.

Health Law section 230(10)(a)(4) and case law¹⁸⁰ permit a CMR if evidence of a single incident of negligence exists, in Dr. Daniels case, it is dubious whether there was evidence to support any negligence at all.¹⁸¹ More importantly, physicians, such as Dr. Daniels, feel persecuted when the OPMC seeks to review any and all office records on the basis of one unfounded complaint.¹⁸²

The AMPA recognized the importance of permitting physicians to practice “legitimate nonconventional medical treatments.”¹⁸³ “Legitimate” was defined as “[e]ffectively treat[ing] human disease, pain, injury, deformity or physical condition.”¹⁸⁴ The BPMC and the New York courts have disregarded the clear legislative mandate that nothing contained in “[a]rticle 131 of the Education Law, which deals with the practice of medicine . . . shall be construed to affect or prevent a licensed physician from using” effective nonconventional medical care.¹⁸⁵ The BPMC and the courts have construed article 131 of the Education Law in such a way as to prevent the effective use of nonconventional medical care by physicians.

For example, a complaint might be filed by a conventional physician alleging that another physician has deviated from the prevailing and acceptable standard of care by the use of a nonconventional treatment. The OPMC would be required to investigate the validity of the complaint.¹⁸⁶ The OPMC would then request that the targeted physician provide the patient’s records, which would likely confirm the physician’s use of a nonconventional treatment.

In order to give nonconventional physicians the safeguards envisioned by the enactment of AMPA, the effectiveness of the

¹⁸⁰ See, e.g., *Tanner*, 228 A.D.2d at 239, 644 N.Y.S.2d at 21.

¹⁸¹ Because complaints are strictly confidential, neither the complainant nor the nature of the complaint is known. See N.Y. PUB. HEALTH LAW § 230(11)(a). It is reasonable, however, to assume that the initial complaint indicated that Dr. Daniels treated a diabetic patient in whole or in part with nutritional supplements.

¹⁸² Some CAM physicians are of the opinion that a complaint based upon an alternative treatment is a pretext for the OPMC to attempt to uncover other more technical violations such as failure to properly maintain patient records, failure to adequately monitor patients, or failure to perform adequate diagnostic tests. See *supra* note 47. Ironically, Dr. Corsello’s charges were primarily based upon excessive tests and treatments. See Corsello Briefs and Fact Sheet, *supra* note 171.

¹⁸³ Holland Memo, *supra* note 86, at 1 (supporting the AMPA).

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*; see also N.Y. EDUC. LAW § 6527(4)(e) (McKinney 1994); Colman Memo, *supra* note 86; Holland Memo, *supra* note 86.

¹⁸⁶ See *supra* notes 100–01 and accompanying text.

nonconventional treatment should be determined before a CMR is ordered or a disciplinary hearing is held. Absent a determination of the treatment's effectiveness, the minimum threshold required by the *Murawski* guidelines or the reasonable basis requirement of Public Health Law section 230(10)(o) easily would be satisfied.¹⁸⁷ Because the complainant is a physician, his reliability would not be questioned by the court.¹⁸⁸ Similarly, the substance of the complaint need not be questioned by the court because it would be presented by the complaining physician together with a supporting affidavit by the OPMC stating that the targeted physician's conduct deviated from the prevailing and acceptable standard of care.¹⁸⁹ Therefore, a motion to compel compliance with either a CMR¹⁹⁰ or a *subpoena duces tecum*¹⁹¹ will always be granted by the court.

Although "the target physician is provided with notice and an opportunity to be heard prior to turning over the requested documents,"¹⁹² the opportunity is severely limited. All of the documentation in support of the OPMC's request to compel compliance would be reviewed by the court in camera. The documentation would include, for example, the complaint, the name of the complainant, and the substance of the complaint or the affidavit by the OPMC in support of the motion.¹⁹³

¹⁸⁷ See N.Y. PUB. HEALTH LAW § 230(10)(o) (McKinney 1994); *Levin v. Murawski*, 59 N.Y.2d 35, 38, 449 N.E.2d 730, 731, 462 N.Y.S.2d 836, 837 (1983). A conventional physician's complaint of another physician's use of nonconventional medicine will satisfy the *Murawski* guidelines. See *supra* notes 136-39 and accompanying text.

¹⁸⁸ See *Murawski*, 59 N.Y.2d at 40, 42, 449 N.E.2d at 732, 733-34, 462 N.Y.S.2d at 838, 839-40; *supra* notes 136-39 and accompanying text. Courts, however, should question the reliability based upon the potential bias or hostility of conventional physicians toward nonconventional physicians' medical care.

¹⁸⁹ See *Murawski*, 59 N.Y.2d at 41-42, 449 N.E.2d at 733-34, 462 N.Y.S.2d at 839-40.

¹⁹⁰ See N.Y. PUB. HEALTH LAW §230(10)(o) (McKinney 1991); see, e.g., *Tanner v. Dr. A.*, 228 A.D.2d 238, 239, 644 N.Y.S.2d 20, 21 (1st Dep't 1996).

¹⁹¹ See, e.g., *Murawski*, 59 N.Y.2d at 38, 449 N.E.2d at 731, 462 N.Y.S.2d at 837; *A'Hearn v. Comm. on Unlawful Practice of the Law of the N.Y. County Lawyers' Ass'n*, 23 N.Y.2d 916, 918, 246 N.E.2d 166, 167, 298 N.Y.S.2d 315, 316 (1969).

¹⁹² *Shankman v. Axelrod*, 73 N.Y.2d 203, 207, 535 N.E.2d 1323, 1324, 538 N.Y.S.2d 783, 784 (1989).

¹⁹³ See *Murawski*, 59 N.Y.2d at 42, 449 N.E.2d at 733-34, 462 N.Y.S.2d at 839-40; *Tanner*, 228 A.D.2d at 239, 644 N.Y.S.2d at 21; *Alter v. N.Y. State Bd. for Prof'l Conduct*, 145 Misc. 2d 393, 395-96, 546 N.Y.S.2d 746, 748 (Sup. Ct. N.Y. County 1989); *Dombroff v. State Bd. For Prof'l. Med. Conduct*, 131 Misc. 2d 472, 475, 500

Therefore, the targeted physician would not know of, or be allowed to examine, any of these documents and could, at best, speculate about the basis of the investigation.¹⁹⁴ In these circumstances, even the best advocates on behalf of the targeted physician might be unable to persuade a court that the OPMC's request for documents is unjustified or is not being made in good faith.

It might, however, be reasonable to speculate that the OPMC has not determined the effectiveness of the nonconventional treatment. Therefore, it might be argued that the investigation, and specifically the requests for a CMR or documents pursuant to a *subpoena duces tecum* are not in good faith.¹⁹⁵ The New York Court of Appeals, in *Murawski*, stated that although the BPMC is required "to investigate each complaint regardless of its source," that requirement is corollary to the preliminary showing "that there be prima facie proof of a justifiable basis for a good faith investigation of professional misconduct."¹⁹⁶ In the event that a supreme court justice orders compliance, the targeted physician would be required to provide the requested documents to the OPMC. The physician's noncompliance could result in a misconduct charge for the failure to cooperate in the investigation.¹⁹⁷ This charge would permit the suspension of the physician's medical license.

Because a BPMC investigation is permitted to extend beyond the sum and substance of a single complaint,¹⁹⁸ records of any and all patients, as well as records of any aspect of the physician's practice, might be sought.¹⁹⁹ Although the initial

N.Y.S.2d 617, 619 (Sup. Ct. N.Y. County 1986).

¹⁹⁴ Typically, in response to a complaint, the OPMC requests the records of a particular patient. Based upon this request, the targeted physician has to speculate regarding the basis of the investigation.

¹⁹⁵ See *Murawski*, 59 N.Y.2d at 41-42; 449 N.E.2d at 733-34, 462 N.Y.S.2d at 839-40.

¹⁹⁶ *Id.* at 41, 449 N.E.2d at 733, 462 N.Y.S.2d at 839.

¹⁹⁷ See N.Y. EDUC. LAW § 6530(15) (McKinney 1994) (stating that cooperation is required); N.Y. PUB. HEALTH LAW § 230(a)(2) (McKinney 1991). Due to Dr. Daniels' unwillingness to permit an unfettered CMR, she was charged with a violation of N.Y. Public Health Law section 230(10)(a)(4). The hearing committee and the ARB suspended her license indefinitely.

¹⁹⁸ See *supra* notes 103, 114-16 and accompanying text.

¹⁹⁹ See, e.g., *Murawski*, 59 N.Y.2d at 38-39, 449 N.E.2d at 731, 462 N.Y.S.2d at 837-38. The BPMC requested any records, documents, and other writings related to either specifically named patients or created within a particular time period. *Id.* at 38, 449 N.E.2d at 731, 462 N.Y.S.2d at 837; see also, *Alter v. N.Y. State Dep't of*

complaint might be based upon a nonconventional treatment, and the CMR based upon a single incident of alleged incompetence, the ultimate charges and determination by the hearing committee and ARB might be totally unrelated to the physician's nonconventional medical practice.²⁰⁰

While the legislature has recognized the important role that licensed physicians play in the use of effective nonconventional medical care in the practice of medicine,²⁰¹ the issue of the effectiveness of nonconventional treatment is avoided by the BPMC and the courts when they only address the physician's failure to comply with conventional medical practices. The only limitation actually imposed by the legislation upon the use of nonconventional medicine is that it be effective.²⁰² In past cases, however, both the BPMC and the New York courts have avoided examinations of the effectiveness of particular nonconventional treatments.²⁰³ Rather, courts have indicated that a

Health, State Bd. for Prof'l Conduct, 145 Misc. 2d 393, 395-96, 546 N.Y.S.2d 746, 748 (Sup. Ct. N.Y. County 1989). In the case of a CMR, the review is broader than the specific request for documents pursuant to a subpoena duces tecum. *See, e.g.,* Tanner v. Dr. A., 228 A.D.2d 238, 239, 644 N.Y.S.2d 20, 21 (1st Dep't 1996). An actual notice of a CMR merely informs the targeted physician that the director of the OPMC is ordering a comprehensive review of patient records. The physician is further informed that the "[s]taff from the Office of Professional Medical Conduct will select a number of [his or her] patient records and other such office records as are related to the issue being reviewed." Attached to the letter notice is an order signed by the chair of the BPMC for a comprehensive review of patient or office records or both. The notice and order, dated June 22, 2000, were served upon Dr. Daniels on or about June 29, 2000. Dr. Daniels indicates that she was informed that the BPMC "wanted to see the records of the 4,000 patients who [had] seen [her] over the prior 10 years." Open Letter from Dr. Daniels (on file with author). The order was based upon a single incident of negligence or incompetence.

²⁰⁰ *See, e.g.,* Gonzalez v. N.Y. State Dep't of Health, 232 A.D.2d 886, 886-87, 648 N.Y.S.2d 827, 829-30 (3d Dep't 1996); Metzler v. N.Y. State Bd. for Prof'l Med. Conduct, 203 A.D.2d 617, 617-18, 610 N.Y.S.2d 334, 335-36 (3d Dep't 1994). In *Gonzalez*, the physician was charged with, inter alia, failure to perform adequate evaluations, failure to perform adequate physical examination, failure to obtain adequate laboratory tests, and failure to maintain accurate records. By comparison, it is interesting to note that the charges against Dr. Corsello were that she ordered excessive tests and engaged in excessive treatments. *See supra* note 171-72 and accompanying text.

²⁰¹ *See* Holland Memo, *supra* note 86; Colman Memo, *supra* note 86.

²⁰² Inherent in this limitation is patient injury or the substantial risk of injury. When patient injury or a risk of injury exists, it is prima facie evidence of ineffectiveness.

²⁰³ *See, e.g.,* Gonzalez, 232 A.D.2d at 887-89, 648 N.Y.S.2d at 830-31; Metzler, 203 A.D.2d at 618, 610 N.Y.S.2d at 336; Atkins v. Guest, 158 Misc. 2d 426, 429-31, 601 N.Y.S.2d 234, 237-38 (Sup. Ct. N.Y. County 1993); *see also* Corsello Briefs and

nonconventional treatment's effectiveness is irrelevant.²⁰⁴ Thereby, physicians have been denied the opportunity to prove effectiveness through expert witnesses, empirical data, and patient testimonials.

Even when the testimony of a targeted nonconventional physician's expert witness has been permitted, administrative judges have inferentially discredited their testimony by affirming the BPMC's finding of physician misconduct.²⁰⁵ Further, appellate courts have consistently held that where there is conflicting testimony between the experts for the BPMC and the experts for the targeted physician, it is an issue of credibility and weight to be resolved by the fact finder.²⁰⁶ Based on the legislative requirement of effectiveness, however, greater weight should be given to the targeted physician's evidence—particularly expert testimony—that establishes that nonconventional medical care is effective.²⁰⁷

The expert testimony submitted by the BPMC has historically contended that nonconventional treatment has not

Fact Sheet, *supra* note 171; Briefs of Dr. Daniels, *supra* note 174.

²⁰⁴ There are no reported cases where a treatment's effectiveness has been raised in the medical disciplinary process. However, in *Schneider v. Revici*, 817 F.2d 987 (2d Cir. 1987), the issue of the effectiveness of the nonconventional treatment was raised in the context of a malpractice action. The court held that the only issue was "whether that treatment [was] a deviation from accepted medical practice in the community." *Id.* at 990. Also, in *Gonzalez*, the physician attempted to introduce evidence related to the treatment's effectiveness. The court held that the excluded evidence at the disciplinary hearing by the administrative officer was harmless error. *Gonzalez*, 232 A.D.2d at 889, 648 N.Y.S.2d at 831.

²⁰⁵ See, e.g., *Gonzalez*, 232 A.D.2d at 889, 648 N.Y.S.2d at 831.; *Metzler*, 203 A.D.2d at 618, 610 N.Y.S.2d at 336.

²⁰⁶ See *Schoenbach v. DeBuomo*, 262 A.D.2d 820, 821–22, 692 N.Y.S.2d 208, 210–11, (3d Dep't 1999); *Gonzalez*, 232 A.D.2d at 889–90, 648 N.Y.S.2d at 831; *Minielly v. Comm'r of Health*, 222 A.D.2d 750, 751, 634 N.Y.S.2d 856, 857 (3d Dep't 1995).

²⁰⁷ See, e.g., *Gonzalez*, 232 A.D.2d at 889, 648 N.Y.S.2d at 831. The physician claimed that the administrative officer erred in his evidentiary ruling by excluding evidence of the effectiveness of the nonconventional treatment. The evidence excluded the physician's "dissertation regarding the theory and protocol underlying his practice" and "a paper containing case studies of patients of a [] dentist . . . each of whom had undergone the same therapeutic protocol and who had successful results." *Id.*, 648 N.Y.S.2d at 830. The court affirmed that the error in the administrative officer's evidentiary ruling was harmless because the physician's expert witnesses testified regarding the same issues. It is interesting to note that the court acknowledged that the physician's experts were "highly respected in their respective fields." *Id.*, 648 N.Y.S.2d at 831. Despite their reputation and their testimony in support of the effectiveness of the nonconventional treatment, the physician's license was revoked based upon negligence and incompetence.

been accepted within the mainstream medical community. The BPMC maintains this position even when the nonconventional medicine at issue is widely used in other states and foreign countries.²⁰⁸ The legislature has envisioned precisely these circumstances and has provided safeguards in the peer review disciplinary process. “[N]o legitimate peer review exists when issues involve clinical practice that is foreign, innovative, or has been shown to be effective, but has not yet achieved general acceptance in the United States.”²⁰⁹

At what point in the disciplinary process can evidence of effectiveness be presented? Physicians are denied the opportunity to provide effective, nonconventional medical care because the BPMC is not required to prove ineffectiveness as early as possible in the disciplinary process. Additionally, the hearing officer is not required to give greater weight to or even admit the physician’s evidence of effectiveness. Furthermore, patients do not have the freedom to choose their medical treatments.²¹⁰ Rather than applying the standard evidentiary rule, that the weight to be given to conflicting expert testimony is solely within the province of the fact finder,²¹¹ the appellate court should apply a rule that acknowledges a respectable minority or “error of judgment.”²¹²

²⁰⁸ For example, “[i]n Germany, homeopathy is a required discipline for all medical students and is used by twenty percent of all German physicians. In France, approximately forty percent of physicians use homeopathic remedies, and in India there are over one hundred thousand homeopathic physicians and one-hundred twenty homeopathic medical schools.” In England, an act of Parliament has recognized homeopathy as a post-graduate medical specialty. “Over forty percent of British physicians either use homeopathic remedies or refer patients to homeopathic physicians. . . . [H]omeopathic hospitals and outpatient facilities are part of the British national health care system.” LARRY TRIVIERI, *THE AMERICAN HOLISTIC MEDICAL ASSOCIATION GUIDE TO HOLISTIC HEALTH* 274 (John Wiley & Sons 2001). In contrast, the BPMC and the court in *Metzler* noted that homeopathy is not recognized in New York. *Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 618, 610 N.Y.S.2d 334, 335 (3d Dep't 1994).

²⁰⁹ Colman Memo, *supra* note 86, at 381.

²¹⁰ See Holland Memo, *supra* note 86 (citing the Court of Appeals decision in *Schloendorff v. New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914), to support the claim that patients have the right to make nonconforming medical decisions); Colman Memo, *supra* note 86 (citing *Atkins* for the same claim).

²¹¹ See, e.g., *Schoenbach*, 262 A.D.2d at 821, 692 N.Y.S.2d at 210–11; *Gonzalez*, 232 A.D.2d at 889–90, 648 N.Y.S.2d at 831; *Minielly*, 222 A.D.2d at 751, 634 N.Y.S.2d at 857.

²¹² See Glen E. Bradford, *The “Respectable Minority” Doctrine in Missouri Medical Negligence Law*, 56 J. MO. BAR 326, 327 (2000) (suggesting that that courts

Courts should reinforce a physician's right to submit any relevant evidence to demonstrate the effectiveness of medical treatments that differ from the acceptable and prevailing medical practice.²¹³ The BPMC and the courts must consider whether a physician exercised his or her best judgment by using "the skill and learning of the average physician, to exercise reasonable care and to exert [his or her] best judgment in the effort to bring about a good result."²¹⁴ An evidentiary rule that provides due weight to a nonconventional physician's expert witnesses would foster accurate assessments of whether a physician used his or her best judgment to offer effective nonconventional health care.

The enactment of the AMPA²¹⁵ gives physicians the right to use effective nonconventional medical care and gives patients the right to choose innovative medical care. To ensure the safeguards intended by AMPA, courts should require the following:

- (1) complaints based upon the use of nonconventional medical care be evaluated at the investigation stage to determine the effectiveness of that care;
- (2) the failure of the BMPC, hearing committee, or the ARB to determine the ineffectiveness of the innovative medical care is prima facie evidence of the lack of good faith necessary to proceed with an investigation;
- (3) ultimate charges and final determination of the hearing committee must be based on the substance of the initial complaint rather than exclusively upon any subsequent discovery of a physician's failure to conform to acceptable conventional medical standards;²¹⁶

should adopt either a reasonableness or a reasonable minority standard in their review of medical board decisions to suspend or revoke a physician's license); see also Barbara D. Goldberg, *As Alternative Treatments Increase, So May Malpractice Claims*, 16(7) MED. MALPRACTICE L. & STRATEGY 1, 2 n.36 (1999); Glenn E. Bradford & David G. Meyers, *The Legal and Regulatory Climate in the State of Missouri for Complementary and Alternative Medicine - Honest Disagreement Among Competent Physicians Or Medical McCarthyism?*, 70 UMKC L. REV. 55, 65-67 (2001); see also *infra* notes 250-53 and accompanying text.

²¹³ Evidence might include expert testimony from non-physician practitioners, such as homeopaths or acupuncturist, nonconventional medical journals and studies, and reports of successful results from patients.

²¹⁴ *Pike v. Honsinger*, 155 N.Y. 201, 210, 49 N.E. 760, 762 (1898).

²¹⁵ See *supra* notes 84-90 and accompanying text.

²¹⁶ See N.Y. PUB. HEALTH LAW §230(10)(a)(iv) (McKinney 1991) (authorizing a

- (4) BPMC must prove the nonconventional treatment's ineffectiveness; and
- (5) the administrative hearing officer must receive evidence on the nonconventional treatment's effectiveness.

Finally, the courts should consider each of the following to be evidence of bias:

- (1) the original complainant is a conventional physician or the BPMC; or
- (2) there is no preliminary determination of ineffectiveness; or
- (3) nonconventional physician members of the BPMC do not constructively participate on either the investigative hearing committees; or
- (4) when nonconventional experts are not consulted on issues of clinical practice.²¹⁷

These recommendations would diminish the vulnerability of CAM physicians like Drs. Corsello and Daniels, to complaints by other physicians and to investigations which may result in the suspension or revocation of their medical licenses simply because their practices deviated from the prevailing and acceptable medical practice.

B. *Unprofessional Conduct Standard*

Since 1914, patients have had the right to determine what is done to their own bodies.²¹⁸ Currently, it is clear that patients have the right "to make an informed decision to go outside currently approved medical methods in search of an

comprehensive medical review board upon a single incident of negligence). However, physicians who practice innovative medicine are particularly vulnerable to complaints of negligence or incompetence or both because their practice by definition does not conform to accepted medical practices. This vulnerability leads to the appearance of persecution to these physicians when (1) their practices have not been determined to be ineffective, (2) there has not been any patient harm or complaint by a patient, and (3) the eventual charges are based upon inadequate or excessive testing, inadequate monitoring, and record keeping.

²¹⁷ Physicians should not otherwise be required to prove bias by individual members of the hearing committee or ARB. *See, e.g., Metzler v. N.Y. State Bd. for Prof'l Med. Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.3d 334, 336 (3d Dep't 1994); *see also supra* text accompanying notes 152–162.

²¹⁸ *See Mrachek v. Sunshone Biscuit, Inc.* 308 N.Y. 116, 123 N.E.2d 801(1954); *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129–130, 105 N.E. 92, 93 (1914) (Cardozo, J.) (applying the rule of respondeat superior and abandoning reliance on whether the act producing the injury was medical or administrative), *overruled on other grounds by Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

unconventional treatment.”²¹⁹ Moreover, an express assumption of risk by patients is an affirmative defense that totally bars a recovery in a malpractice claim.²²⁰ Therefore, when such an express assumption occurs, physicians are permitted to deviate from the duty to treat patients according to the prevailing and accepted medical community’s standards.²²¹ However, although a physician’s liability may be diminished in a malpractice claim due to patients’ consent to assume the risk associated with nonconventional treatments, the physician may still be subject to license revocation in a medical disciplinary action because that same conduct deviated from the medical community’s standards.²²²

“[P]rofessional licensing discipline cases frequently turn on standard of care issues.”²²³ Most states have enacted legislation requiring medical boards to investigate all complaints received.²²⁴ This legislation, however, has often failed to provide guidelines for medical boards to determine which complaints merit proceeding to a hearing.²²⁵ Other statutes have provided medical boards with too much discretion by allowing an investigation and sanction of physicians for any departure from prevailing medical practices.²²⁶ The medical boards and the courts in *Metzler*, *Gonzalez*, and *In re Guess* applied the standard that a physician’s conduct must conform to acceptable medical practices.²²⁷ This standard of care is essentially the equivalent

²¹⁹ *Schneider v. Revici*, 817 F.2d 987, 995 (2d Cir. 1987).

²²⁰ *See id.* (explaining that while assumption of risk was a bar to recovery prior to 1975, now contributory negligence merely diminishes recovery).

²²¹ *See Boyle v. Revici*, 961 F.2d 1060, 1062 (2d Cir. 1992).

²²² *See, e.g., Metzler*, 203 A.D.2d at 618; 610 N.Y.S.2d at 336.

²²³ Bradford, *supra* note 212; Bradford & Meyers, *supra* note 212, at 58.

²²⁴ *See, e.g., N.Y. PUB. HEALTH LAW* § 230(10)(i) (McKinney 1996) (“The board for professional medical conduct . . . shall investigate each complaint received regardless of the source.”).

²²⁵ *See id.* § 230(10)(a)(iv) (“If the director of the office of professional medical conduct, after obtaining the concurrence of a majority of an investigation committee, and after consultation with the executive secretary, determines that a hearing is warranted the director shall . . . direct counsel to prepare the charges.”).

²²⁶ *See In re Guess*, 393 S.E.2d 833, 834–36 (N.C. 1990) (citing N.C. GEN. STAT. § 90-14(a)(6) (1985)); *see also* Cohen, *supra* note 23, at 88, 150.

²²⁷ The standard may be statutorily defined as in *In re Guess*, 393 S.E.2d at 835–36. *See supra* notes 39–45 and accompanying text. On the other hand, it may be judicially defined as in *Metzler*, 203 A.D.2d at 618–19, 610 N.Y.S.2d at 336. *See supra* notes 32–38 and accompanying text; *see also* Cohen, note 23, at 121–22.

of the standard applied by the courts in medical malpractice cases.²²⁸

An important difference in professional misconduct complaints filed against nonconventional physicians, however, "is that it is generally not required that the state medical board establish that the questioned medical care caused injury."²²⁹ For that matter, most medical boards are not even required to prove a *risk* of patient injury.²³⁰

For a physician to be found negligent in a medical disciplinary proceeding, New York courts have consistently held that patient injury²³¹ or even a "foreseeable risk of injury to a *specific* patient" is unnecessary.²³² The *Bogdan* and *Morfesis* courts, like the *Metzler* and *Gonzalez* courts, found that the applicable standard was whether "a physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances."²³³ Unlike *Metzler* and *Gonzalez*, the physicians in *Bogdan* and *Morfesis* were conventional practitioners. This is significant because the standard for conventional practitioners must be that of the "reasonably prudent physician." There is no other reasonable standard by which to evaluate their conduct. Also, the *Bogdan* and *Morfesis* cases were decided prior to the enactment of the AMPA of 1994.²³⁴ While the *Metzler* and *Gonzalez* cases were decided by the Appellate Division, Third Department, after the enactment

²²⁸ See Bradford & Meyers, *supra* note 212, at 56–57; see also Nestorowich v. Ricotta, 97 N.Y.2d 393, 398, 767 N.E.2d 125, 128, 740 N.Y.S.2d 668, 671 (2002) (discussing malpractice standard in New York).

²²⁹ Bradford & Meyers, *supra* note 212, at 58 n.26 (citing Swope v. Printz, 468 S.W.2d 34, 39 (Mo. 1971)).

²³⁰ See *In re Guess*, 393 S.E.2d at 838; see also *Gonzalez v. N.Y. State Dep't of Health*, 232 A.D.2d 886, 889–90, 648 N.Y.S.2d 827, 831 (3d Dep't 1996). To the extent that medical boards aggressively pursue physicians who integrate CAM into their medical practices "without a showing of patient injury ignore that there are at least three competing interests at stake (the profession's, the individual physician's and the public's)." Cohen, *supra* note 23, at 150.

²³¹ See *Morfesis v. Sobol*, 172 A.D.2d 897, 898–99, 567 N.Y.S.2d 954, 956 (3d Dep't 1991).

²³² See *Bogdan v. N.Y. Bd. for Prof'l Med. Conduct*, 195 A.D.2d 86, 89, 606 N.Y.S.2d 381, 382 (3d Dep't 1993).

²³³ *Id.* at 88, 606 N.Y.S.2d at 382. The court in *Morfesis* held that the physician's conduct must not deviate from accepted standards. *Morfesis*, 172 A.D.2d at 898–99, 567 N.Y.S.2d at 956.

²³⁴ The New York Act of 1994, Ch. 558, §§ 1, 2, 1994 N.Y. Laws, amended one section of the New York Education Law § 6527(4)(e) and two sections of the New York Public Health Law, §§ 230(1), 230(10)(a)(ii).

of AMPA, neither case raised the issue of patient injury or the risk of patient injury.²³⁵

Nevertheless, in *Gonzalez*, the appellate division cited to *Bogdan* for the proposition that the applicable standard for medical disciplinary cases is that the physician must “exercise the care that a reasonably prudent physician would exercise under the circumstances.”²³⁶ Therefore, it is reasonable to assume that the court would reject the argument that either patient harm or the risk of patient harm is a prerequisite to a finding of misconduct, particularly negligence or incompetence, in medical disciplinary proceeding against nonconventional physicians.

Like the North Carolina statute in *In re Guess*,²³⁷ the New York statutory scheme “is directed to protecting the health and safety of patients and the public.”²³⁸ Furthermore, “[t]he common thread running through each of [the] reasons for revocation of a license is the threat or potential for harm to patients and the public.”²³⁹ “The public policy at the root of the bill [Public Health Law section 230] was to prevent a physician from causing, engaging in or maintaining a condition or activity which constitutes an imminent danger to the health of the people.”²⁴⁰ Absent proof of patient injury, or the risk thereof, or proof of the treatment’s ineffectiveness, physicians who use innovative medical care do not constitute “an imminent danger to the health of the people.”²⁴¹

²³⁵ The *Gonzalez* decision was subsequent to the enactment of AMPA. The physician’s hearing and the hearing committee’s decision were prior to the passing of AMPA. The court concluded that “in the absence of any indication of legislative intent to provide retroactivity... the legislation should only be applied prospectively.” *Gonzalez*, 232 A.D.2d at 888; 648 N.Y.S.2d at 830 (citations omitted). The court in *Morfesis* affirmed the administrative decision that the physician’s conduct deviated from accepted standards. *Morfesis*, 172 A.D.2d at 897, 567 N.Y.S.2d at 956.

²³⁶ *Gonzalez*, 232 A.D.2d at 889, 648 N.Y.S.2d at 831.

²³⁷ See *In re Guess*, 393 S.E.2d 833, 835–36 (N.C. 1990).

²³⁸ *Id.* at 840 (Frye, J., dissenting); see also Memorandum of Assemb. Hevesi, reprinted in 1977 N.Y. ST. LEGIS. ANN. 773.

²³⁹ *In re Guess*, 393 S.E.2d at 840–41 (Frye, J., dissenting).

²⁴⁰ *Atkins v. Guest*, 158 Misc. 2d 426, 431, 601 N.Y.S.2d 234, 238 (Sup. Ct. N.Y. County 1993) (citing Memorandum of Assemb. Hevesi, reprinted in 1977 N.Y. ST. LEGIS. ANN. 773).

²⁴¹ *Id.*, 601 N.Y.S.2d at 238.

The reported facts in *Metzler* and *Gonzalez*, however, do not indicate that a patient was injured.²⁴² The charges against both physicians included gross negligence, negligence on more than one occasion, and failure to maintain records.²⁴³ In both cases, the facts upon which the physicians were charged, found guilty, and had their license suspended or revoked essentially stemmed from their failure to perform conventional physical examinations, appropriate assessments, conduct adequate laboratory tests or diagnostic studies, and provide sufficient follow-up or monitoring.²⁴⁴ Unlike *In re Guess*, where the physician was charged with practicing homeopathy,²⁴⁵ the physicians in *Gonzalez* and *Metzler* were in essence charged with not practicing conventional medicine. This conclusion runs against the goals of the AMPA.

The AMPA was enacted to protect nonconventional physicians from being charged with and sanctioned for the practice of effective nonconventional medicine. Therefore, there must be proof either that the nonconventional therapy is ineffective, that it poses a greater risk of patient injury than conventional medicine, or that it in fact caused injury rather than a mere designation of being nonconventional in order for charges of the failure to practice conventional medicine to be affirmed by the courts.

Reminiscent of the philosophical battles between the AMA and homeopathic physicians in the early twentieth century,²⁴⁶

²⁴² See *supra* notes 32–52 and accompanying text. In *Metzler*, “[t]he Committee unanimously concluded that the petitioner’s treatment of one of his patients, who died from pneumocystic pneumonia and was suffering from AIDS, did not meet the minimum standards of acceptable medical practice and was so egregious as to constitute gross negligence.” *Metzler v. N.Y. State Bd. for Prof’l Med. Conduct*, 203 A.D.2d 617, 618, 610 N.Y.S.2d 334, 335 (3d Dep’t 1994). The court, and perhaps the hearing committee, did not specify how the physician’s conduct failed to meet the minimum standards. See *generally id.*, 610 N.Y.S.2d at 335.

²⁴³ In addition, Dr. Gonzalez was charged with gross incompetence and with gross incompetence on more than one occasion. *Gonzalez v. N.Y. State Dep’t of Health*, 232 A.D.2d 886, 886, 648 N.Y.S.2d 827, 829 (3d Dep’t 1996).

²⁴⁴ See *id.*, 648 N.Y.S.2d at 829; *Metzler*, 203 A.D.2d at 618, 610 N.Y.S.2d at 336.

²⁴⁵ See *In re Guess*, 393 S.E.2d 833, 834–35 (N.C. 1990). “[T]he [b]oard charged Dr. Guess with unprofessional conduct . . . specifically based upon his practice of homeopathy. . . . The [b]oard further alleged that the use of homeopathic medicines ‘departs from and does not conform to the standards of acceptable and prevailing medical practice in the State of North Carolina.’” *Id.* at 834–35.

²⁴⁶ See *generally supra* note 11. Some would argue that the battle was more economic than philosophical. See *Andrews, supra* note 9, at 1288–89; *Boozang,*

however, the *Metzler* hearing committee, ARB, and the court expressly noted, that “homeopathy is not recognized in New York State as a separate branch of medicine nor is petitioner separately licensed as a homeopathic physician.”²⁴⁷ By recasting the charges from practicing homeopathy to not practicing conventional medicine consistent with the acceptable and prevailing medical practice, the statutory authority that permits physicians to use effective nonconventional medical care is undermined.²⁴⁸ Suspension or revocation of nonconventional physicians’ licenses for the failure to maintain the standards of conventional physicians is particularly egregious where there is no evidence of patient harm; the alleged violations are related to conventional medical practices, such as laboratory and diagnostic testing, follow-up evaluations and monitoring, and maintaining accurate records; and when the patients fully and adequately consented to the nonconventional treatment.²⁴⁹

It is axiomatic that there are significant differences in the philosophical underpinnings and practices between conventional and nonconventional health care.²⁵⁰ Due to these differences, nonconventional medical practices such as homeopathy and acupuncture involve different diagnostic procedures or evaluations than conventional medicine.²⁵¹ Based upon the

supra note 1, at 186.

²⁴⁷ *Metzler*, 203 A.D.2d at 618, 610 N.Y.S.2d at 335. The hearing committee, administrative review board, and the court “noted that there are no different standards for licensed physicians based upon their philosophy.” *Id.* at 619, 610 N.Y.S.2d at 336. The court also held that neither the hearing committee nor the review board are required to have a member who practices nonconventional medicine, much less one of the same philosophy of the reviewed physician. *Id.*, 610 N.Y.S.2d at 336; *see supra* notes 152–67 and accompanying text (discussing disciplinary procedures and committee members).

²⁴⁸ *See* N.Y. EDUC. LAW § 6527(4)(e) (McKinney 1994); *see supra* note 184.

²⁴⁹ *See* *Gonzalez v. N.Y. State Dep’t of Health*, 232 A.D.2d 886, 888, 648 N.Y.S.2d 827, 830 (3d Dep’t 1996); *Metzler*, 203 A.D.2d at 617–18, 610 N.Y.S.2d at 336. In both cases, the court held that “it is well settled that a patient’s consent to or even insistence upon a certain treatment does not relieve a physician from the obligation of treating the patient with the usual standard of care.” *Gonzalez*, 232 A.D.2d at 888, 648 N.Y.S.2d at 830 (quoting *Metzler*, 203 A.D.2d at 619, 610 N.Y.S.2d at 336).

²⁵⁰ *See* *Andrews*, *supra* note 9, at 1288–89 (discussing philosophical difference between conventional and nonconventional medicine); *Boozang*, *supra* note 1, at 186; *see also Metzler*, 203 A.D.2d at 617–18, 610 N.Y.S.2d at 335–36 (recognizing different branches in philosophy of medicine). *See generally*, *Cohen*, *supra* note 23, at 139.

²⁵¹ For example, the typical diagnostic procedure for acupuncture includes four

initial evaluations, the homeopathic physician or the physician who practices acupuncture will develop treatment plans accordingly.²⁵² When physicians offer nonconventional medical care, they are, by definition, departing from “conventionally accepted medical standards.”²⁵³ Therefore, the assessment of the standard of care for nonconventional physicians should be measured by whether it deviates from the degree of knowledge and skill possessed or the degree of care ordinarily exercised by similarly practicing health care providers under similar circumstances.²⁵⁴ Accordingly, homeopathic physicians’ conduct should be evaluated by the accepted homeopathic standard of care.²⁵⁵ When there is not a recognized “school” for the nonconventional medical care, a “general reasonableness standard” should be applied.²⁵⁶

basic techniques: observation, palpitation, interviewing, and listening. The practitioner observes the condition of the patient’s face, hair, skin, and nails, and also observes how the patient stands and walks. The practitioner palpates pressure points and takes twelve pulse readings, six on each wrist. The practitioner interviews the patient to elicit data that facilitates an assessment of the primary elemental energy imbalance of the five energies: wood, fire, earth, metal, and water. The practitioner also listens to the patient’s voice to clarify the primary energy imbalance. See *Acupuncture*, at <http://www.healthhelper.com/complementary/alternative/acupuncture.htm> (last visited Mar. 25, 2003); *Acupuncturist Diagnosis*, at <http://www.aworldofacupuncture.com/acupuncture-diagnosis.htm>; see also TRIVIERI, *supra* note 208, at 353–56; Cohen, *supra* note 23, at 109.

²⁵² See *supra* note 251.

²⁵³ See Cohen, *supra* note 23, at 109.

²⁵⁴ See Cohen & Eisenberg, *supra* note 20 (explaining that “alternative schools of medicine” also apply the “reasonable practitioner standard” so that the “osteopath is held to the ‘reasonable practitioner’ standard, that is, an osteopath is held to the ‘reasonable osteopath’ standard and a naturopath is held to the ‘reasonable naturopath’ standard.”); Doyle, *supra* note 6, at 549. CAM-practicing physicians will likely be held to a higher standard because of “a general reluctance to place even established alternative schools on a level with conventional medicine when determining standard of care.” Cohen & Eisenberg, *supra* note 20, at 549; see also Goldberg, *supra* note 212. The public policy concerns of legislation intended to protect nonconventional physicians, such as NY AMPA, “support the use of a general ‘reasonableness’ standard of care, rather than the narrower ‘accepted practice’ standard, where the alternative practitioner does not belong to any particular ‘school’ that could define accepted practice.” *Id.* Some advocate the use of the reasonableness standard in the context of medical malpractice strategies to be used on behalf of CAM physicians. *Id.* The standard, however, is equally applicable, if not more so, in the context of disciplinary action because the AMPA was primarily intended to protect CAM physicians charged with misconduct. See *supra* notes 85–90 and accompanying text.

²⁵⁵ See, e.g., THE SOCIETY OF HOMEOPATHS, CODE OF ETHICS AND PRACTICE (2001); see also Boozang, *supra* note 1, at 207; COHEN, *supra* note 17, at 64–66.

²⁵⁶ Goldberg, *supra* note 212, at 4 (indicating that the use of a reasonableness

Currently, the New York courts require all nonconventional physicians to practice conventional medicine.²⁵⁷ The courts are interpreting the legislative intent that allows physicians to use effective nonconventional medical care to mean that nonconventional physicians must comply with the accepted and prevailing medical practice. No consideration has been given to whether the standard of care for the nonconventional treatment was met or, more importantly, whether the nonconventional treatment was effective.²⁵⁸ Furthermore, consideration is not given to whether physicians use nonconventional medical care exclusively or if they have also assumed responsibility for patients' primary care. All physicians, including nonconventional physicians, who assume responsibility for patients' primary care should be required to conform to the accepted and prevailing medical practice. For example, Dr. Metzler, who exclusively practiced homeopathy, informed his patients that "he approaches 'health care as a primary care practitioner who can treat all [their] ailments. If additional care is needed, such as surgery, then [he] desire[s] to be contacted first so [he] can coordinate the additional care.'"²⁵⁹ Under circumstances such as these, the ARB and the court should apply "the minimum standards of acceptable medical practice."²⁶⁰ Nonconventional primary care physicians are not entitled to the application of standards that differ from conventional primary care physicians. Patients are entitled to rely upon their expectation gained from experience with primary care physicians that conventional medical practices will be used. Physicians who exclusively use nonconventional medical care and obtain patient

standard in medical malpractice cases in which there are no recognized or accepted schools within which some of the unique nonconventional medical treatments may belong).

²⁵⁷ See *Gonzalez v. N.Y. State Dep't of Health*, 232 A.D.2d 886, 888, 648 N.Y.S.2d 827, 830 (3d Dep't 1996); *Metzler v. N.Y. State Bd. of Prof'l Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.2d 334, 336 (3d Dep't 1994).

²⁵⁸ See N.Y. EDUC. LAW § 6527(4)(e), *supra* note 185. The *Gonzalez* court noted that both the hearing committee and the administrative review board "recognized that alternative medicine involves a different treatment regime . . . [w]ithout questioning the merits of [the physician's] therapeutic protocol." The court stated that the basic medical standards "do not vary based on the treatment regime." *Gonzalez*, 232 A.D.2d at 888, 648 N.Y.S.2d at 830.

²⁵⁹ *Metzler*, 203 A.D.2d at 618, 610 N.Y.S.2d at 335.

²⁶⁰ *Id.*, 610 N.Y.S.2d at 335.

consent, however, should be held to the standard of care defined by the nonconventional practice.²⁶¹

As part of patients' informed consent to nonconventional medical care,²⁶² physicians should include an explicit notice to patients stating that they are not primary care physicians. Further, patients should be advised to continue consulting with or begin to consult a primary care physician. With proper consent and patient advice, physicians who choose to practice nonconventional medicine should be charged with medical misconduct only when the BPMC proves that the practice was ineffective, that there was patient harm or risk thereof,²⁶³ or that the physician deviated from the nonconventional practice standard.²⁶⁴

C. Legislative Reform

The legislative intent of the AMPA of 1994 was to permit physicians to use effective nonconventional medical care²⁶⁵ in order to assure that those "charged with misconduct [would] receive "fair consideration by those best qualified to judge his or her practice and methods of treatment" and to enhance the quality of care "through the constructive participation of nonconventional physicians in the disciplinary process."²⁶⁶ This intention has been undermined by the BPMC. The BPMC, through the OPMC, has not recognized a nonconventional medical practitioner's right to peer review by a disciplinary process that includes at least one nonconventional physician at any stage. Indeed, the BPMC has selected conventional medical experts pursuant to Public Health Law section 230(10)(1)(ii) in a case in which a nonconventional physician's alleged misconduct charges involved her clinical practice.²⁶⁷ In that instance, the conventional medical expert admitted that

²⁶¹ See, e.g., *Gonzalez*, 232 A.D.2d at 888, 648 N.Y.S.2d at 830; *Metzler*, 203 A.D.2d at 619, 610 N.Y.S.2d at 336; see also *supra* notes 248–53 and accompanying text.

²⁶² See *supra* notes 218–22 and accompanying text.

²⁶³ See *supra* notes 224–36 and accompanying text.

²⁶⁴ See *supra* notes 212–41 and accompanying text.

²⁶⁵ See *supra* note 183.

²⁶⁶ Holland Memo, *supra* note 86; Colman Memo, *supra* note 86.

²⁶⁷ See Corsello Briefs and Fact Sheet, *supra* note 171. The choice of conventional medical experts to review the clinical practice of physicians who practice innovative medicine is inconsistent with the spirit of AMPA and legislative intent. *Id.*; see also Holland Memo, *supra* note 86; Colman Memo, *supra* note 86.

[m]any of the modalities used by Dr. Corsello are foreign to me. It would take a massive amount of research to establish them as non-efficacious and possibly harmful. Mr. Fischer has informed me that the burden of proof is upon Dr. Corsello to defend them as safe and efficacious In a book on alternative medicine just published by the AMA, I found no reference to the methods in her practice.²⁶⁸

Requests by Dr. Corsello that the BPMC consult an expert familiar with nonconventional medical care were denied.²⁶⁹ The BPMC has also taken the position that nonconventional physicians are not required to participate on the investigation or hearing committees, or on the ARB.²⁷⁰

The appellate courts have not reviewed the question of whether nonconventional medical experts must be consulted when complaints involve the clinical practice of nonconventional physicians. The amendment to Public Health Law section 230(10)(o)(ii), however, specifically provided that, when there are issues involving the clinical practices of nonconventional physicians, experts may be made available "by New York State

²⁶⁸ Letter from Arthur Tomases, M.D. to Mr. Sheehan of the OPMC (Mar. 2, 2002) (on file with author). Despite Dr. Tomases admitted unfamiliarity with CAM and his inability to thoroughly research the medical care provided by Dr. Corsello, he did submit a report. The report is currently unavailable. Dr. Corsello was charged with excessive testing and treatment even though the expert, and therefore the OPMC, had no appreciation of the nature of Dr. Corsello's clinical practice.

²⁶⁹ See Letter from Roy Nemerson, Deputy Counsel, Bureau of Professional Medical Conduct, to Wilfred T. Friedman, Esq., Attorney to Dr. Corsello (Aug. 14, 2002) (on file with author). In the letter, Mr. Nemerson wrote:

Your letter is incorrectly premised on an assumption that Dr. Corsello has the right to choose the medical expert the Department consults. Please be advised that the Department chooses its expert based upon their qualifications to testify with regard to the standard of practice to which physicians are held. She holds herself out as a physician. She practices the profession of medicine. The Department will present appropriate expert testimony regarding minimally acceptable standards for the practice of medicine as relevant to the facts of the case. I will be signing the charges in the matter based on the expert review already obtained.

Id.; Letter from Terrence J. Sheehan, Esq., Associate Counsel, Bureau of Professional Medical Conduct, to Wilfred T. Friedman, Esq. (Aug. 22, 2000) (on file with author) (wherein Mr. Sheehan stated, "[i]n reply to your letter dated July 16, 2000, please be advised that this office denies your request to have this case reviewed by a different medical reviewer"); Letter from Roy Nemerson, Deputy Counsel, Bureau of Professional Conduct to Wilfred T. Friedman, Esq. (Sept. 5, 2000) (on file with author) (reaffirming an earlier decision to deny the physician's request for an expert who would be better qualified to judge her practice and treatments).

²⁷⁰ See Letter from Roy Nemerson to Wilfred Friedman, *supra* note 269.

medical associations dedicated to the advancement of nonconventional treatments.”²⁷¹ In cases such as Dr. Corsello’s, nonconventional physician experts should be consulted to review the targeted physician’s clinical practice.

The appellate courts have denied physicians’ claims that a nonconventional physician member of BPMC must participate on either the hearing committee or the ARB.²⁷² Nonconventional physicians’ “guarantee [of] legitimate due process” has been effectively denied by the combination of the BPMC’s policy to refuse to consult nonconventional physician experts and with court decisions that Public Health Law section 230 does not require participation by nonconventional physicians in the disciplinary process.²⁷³

Physicians who have been charged with and investigated for the use of nonconventional health care have not had their choice of treatment reviewed for its effectiveness. Instead, these physicians have been investigated for and charged with the failure to conform with conventional medical practices.²⁷⁴ The OPMC’s investigation of physicians for the use of nonconventional medical care has been a pretense to uncover any shortcomings in the practice of nonconventional medicine.²⁷⁵

“[B]efore the investigative engines of governmental agencies are started up against”²⁷⁶ physicians who practice innovative medicine, the pre-investigative good faith requirement must include an assessment of the effectiveness of the medical care.

²⁷¹ See Holland Memo, *supra* note 86.

²⁷² See *Gonzalez v. N.Y. State Dep’t of Health*, 232 A.D.2d 886, 888, 648 N.Y.S.2d 827, 830 (3d Dep’t 1996); *Metzler v. N.Y. State Bd. of Prof’l Med. Conduct*, 203 A.D.2d 617, 619, 610 N.Y.S.2d 334, 336 (3d Dep’t 1994).

²⁷³ See Holland Memo, *supra* note 86; Colman Memo, *supra* note 86.

²⁷⁴ See, e.g., *Gonzalez*, 232 A.D.2d at 888, 648 N.Y.S.2d at 830; *Metzler*, 203 A.D.2d at 619, 610 N.Y.S.2d at 336; *Atkins v. Guest*, 158 Misc. 2d 426, 427–28, 601 N.Y.S.2d 234, 235–36 (Sup. Ct. N.Y. County 1993); Corsello Briefs and Fact Sheet, *supra* note 171, at 3; Briefs of Dr. Daniels, *supra* note 174.

²⁷⁵ Although each of the physicians were initially investigated because of their innovative medical practice, they were most frequently charged with inadequate record keeping, inadequate testing, follow-ups, monitoring, and excessive testing. See, e.g., *Gonzalez*, 232 A.D.2d at 886–87, 648 N.Y.S.2d at 829; *Metzler*, 203 A.D.2d at 617–19, 610 N.Y.S.2d at 335–36; *supra* notes 238–41 and accompanying text. To date, none of the physicians were found guilty of the practice of ineffective nonconventional medical care. It is inconceivable that the complaints against these physicians were based upon inadequate record keeping and testing.

²⁷⁶ *Levin v. Murawski*, 59 N.Y.2d 35, 41, 449 N.E.2d 730, 733, 462 N.Y.S.2d 836, 839 (1983).

Furthermore, the BPMC should be required to charge and prove ineffectiveness of the medical care at the disciplinary hearing. A focus on the treatment's effectiveness also shifts the standard of care from acceptable and prevailing medical practice to the particular nonconventional standard of care.²⁷⁷

The OPMC's methods have had "an indisputable chilling effect on the practice of nonconventional therapies by licensed physicians."²⁷⁸ Physicians have become acutely aware of the risk posed to their licenses and reputations by the use of innovative therapies.²⁷⁹ The New York State Legislature needs to provide more specific guidelines for the BPMC and the courts in order to ensure legitimate due process for physicians who practice innovative medical care and to protect the freedom of patients to choose their own medical treatments.²⁸⁰

Based on the foregoing, legislative reform is necessary and should include the following measures:²⁸¹

- (1) The OPMC should be required to consult medical experts dedicated to the advancement of nonconventional medical treatment when a complaint against a CAM physician involves issues of clinical practice;

²⁷⁷ See *supra* notes 250–256 and accompanying text.

²⁷⁸ Colman Memo, *supra* note 86 (supporting the AMPA).

²⁷⁹ See generally Burton Goldberg, *supra* note 84; COHEN, *supra* note 166. In January 2002, Monica Miller, on behalf of the Foundation for the Advancement of Innovative Medicine, testified before the NYS Legislator on the disciplinary process for physicians. Monica Miller, *Testimony On the Disciplinary Process for Physicians and Physician Assistants*, available at www.healthlobby.com/OPMC%20testimony.htm (last visited Mar. 25, 2002). She was asked the question whether there are "classes of physicians . . . that are uniquely targeting for investigation." *Id.* Her response was that "the classes include[d] but are not limited to: [p]hysicians diagnosing and treating chronic Lyme disease, doctors affiliated with complementary and alternative medicine, foreign graduates, and persons with Hispanic or Middle-Eastern names." *Id.*

²⁸⁰ See generally Colman Memo, *supra* note 86; Holland Memo, *supra* note 86.

²⁸¹ Currently pending before the New York State Legislature is S.7466/A.11330b that seeks "to make the process more reasonable, less secretive and provides redress for the availability of new evidence and disputes about rulings. It strengthens the essential elements of due process: notice and an opportunity to be heard." Final Draft of the Commentary and Recommendation 2 (Sept. 27, 2002) (on file with author). The Health Law Section of the New York State Bar Association has submitted "Commentary and Recommendations," regarding policies and procedures of the OPMC. *Id.* Their submission addresses such issues as the interview process, discovery, specificity of charges, and consideration of a statute of limitation. *Id.* These observations and recommendations do not specifically address the unique concerns of physicians who practice CAM. *Id.*

- (2) The OPMC should foster constructive participation by a nonconventional physician by an appointment to the investigative or hearing committee or both;
- (3) The OPMC should be required to demonstrate a prima facie case that the nonconventional medical treatment is ineffective before conducting a CMR or issuing a *subpoena duces tecum*;
- (4) Physicians should be permitted to submit evidence of the effectiveness and acceptance of the innovative medical care from other communities including CAM journals.²⁸² The lack of acceptableness by the general conventional community should not be considered evidence of ineffectiveness. The OPMC should be required to submit evidence in the nature of studies or reports that support the conclusion of ineffectiveness. The OPMC should have the burden of proving ineffectiveness or patient harm;
- (5) Physicians who exclusively practice innovative medical care and have not assumed primary care responsibility for patients should have their standard of care determined by the reasonableness of their judgment.²⁸³ These physicians should not be subject to misconduct charges for failure to practice conventional medicine (e.g. diagnostic testing, adequate follow-ups and record keeping). They should, however, be required to obtain informed consent that includes advice to the patient to seek a primary care physician.²⁸⁴

As an alternative to suggestion five, legislation might be enacted that clearly advises physicians of their obligation to maintain aspects of their conventional practice.²⁸⁵ For example, the states of Louisiana,²⁸⁶ Nevada,²⁸⁷ and Texas²⁸⁸ have enacted

²⁸² See *Day v. Aetna-Employees Ben. Div.*, 1989 WL 69718 (Ohio Ct. App. 1989) (stating that the trial judge accorded greater weight to an article submitted by plaintiff from the *Journal of Holistic Medicine*).

²⁸³ See *Sherman v. Bd. of Regents*, 24 A.D.2d 315, 318, 266 N.Y.S.2d 39, 43 (3d Dep't 1966), *aff'd* 19 N.Y.2d 679, 225 N.E.2d 560, 278 N.Y.S.2d 870 (1967); *Gieleskie v. New York*, 10 A.D.2d 471, 474, 200 N.Y.S.2d 691, 694 (3d Dep't 1960), *aff'd*, 9 N.Y.2d 834, 175 N.E.2d 455, 216 N.Y.S.2d 86 (1961); see also *supra* notes 210–12 and accompanying text.

²⁸⁴ See *Corsello Briefs and Fact Sheet*, *supra* note 171, at 1. Dr. Serafina Corsello, as part of her integrative medical practice, maintains an office policy that requires patients to have a conventional provider as a primary care physician. *Id.*

²⁸⁵ See *supra* notes 93–95 and accompanying text (discussing general due process right to notice).

²⁸⁶ LA. REV. STAT. ANN. § 37:1285.3 (West 1999).

²⁸⁷ NEV. REV. STAT. ANN. § 630.3062 (Michie 2000).

²⁸⁸ 22 TEX. ADMIN. CODE § 200.1–200.3 (West 1998).

legislation which provides that physicians must conduct a full evaluation of the patient, including conventional methods of diagnosis, such as addressing relevant medical history and conducting an appropriate physical examination, offering a medical diagnosis and patient treatment plan, and obtaining informed consent, prior to offering any nonconventional medical therapy. The legislation should also clearly inform physicians of the extent to which they are obligated to maintain adequate conventional records, monitoring, and follow-up evaluations.

CONCLUSION

The New York State Legislature enacted the AMPA of 1994 with the intent to protect "the rights of nonconventional physicians throughout the misconduct process" and to secure "the rights and freedom of patients to choose their own medical treatments."²⁸⁹ However, the policy and practices of the BPMC, particularly through the OPMC, and judicial construction have severely restricted the intended impact of the legislation. These practices and court decisions have indeed had a chilling effect on physicians who might consider integrating innovative medical care into their practices. Physicians who currently use any innovative medical care in their practices have been particularly vulnerable to charges of professional misconduct. Physicians who have been investigated and charged with misconduct by the OPMC have faced financial devastation, loss of reputation, and the eventual revocation of their medical licenses. Tens of thousands of patients have simultaneously lost their choice of medical treatment and physician. In addition, because of the limited availability of physicians who practice innovative medicine and the chilling effect of the risks associated with the practice of nonconventional medicine by others who may consider it, these patients will be severely limited in their future choice of medical treatment.

As the two published studies in the *New England Journal of Medicine* and the *Journal of American Medical Association* have indicated, more people have been consulting CAM providers than conventional physicians. It is expected that consumer spending in this area will grow by as much as thirty percent. Some physicians and consumers consider the reason for the current

²⁸⁹ Holland Memo, *supra* note 86; Colman Memo, *supra* note 86.

practices of the OPMC to be the same reason for the policies and practices of the AMA throughout most of the twentieth century—economics.

With the goal of reassuring the “safeguard [of] patient’s rights and [the] guarantee [of] legitimate due process for nonconventional physicians”²⁹⁰ have come certain proposals for reform. On a judicial level, reform would require the expansion of the pre-investigative stage of a complaint. To meet the good faith requirement, the OPMC should hire nonconventional medical experts to evaluate the effectiveness of the innovative medical treatment. In order to satisfy the legislative intent to provide “constructive participation” by the nonconventional physicians appointed to the BPMC, courts should require their appointment to investigative or hearing committees. Finally, the standard of care should be revised from the accepted and prevailing medical standard to an examination of the effectiveness of the innovative health care. This could be achieved through application of either the respectable minority or “error of judgment” doctrines.

On a legislative level, the proposals for reform are intended to provide clear guidance and direction to the BPMC and the courts to reaffirm the guarantee of legitimate due process to nonconventional physicians and to safeguard the freedom of patients to choose their own medical treatments. The legislative proposals should better define the following: (1) the right of physicians to use whatever medical care that effectively treats their patients, (2) the requirement of the use of nonconventional medical experts who evaluate the clinical practices of targeted physicians who use innovative medicine, (3) the meaning of “constructive participation” by the two nonconventional physicians on the BPMC, and (4) the standard of care applicable to physicians who use innovative medicine. Both the judicial and legislative proposals will help to better align New York State medical care with the twenty-first century trend of integrative health care.

²⁹⁰ *Supra* note 86.