COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. **Division of Administrative Law Appeals**

Board of Registration in Medicine,
Petitioner,

v.

Lee S. Altman, M.D.,
Respondent.

No. RM-19-412

Dated: October 26, 2023

Appearance for Petitioner:
James Paikos, Esq.

Appearance for Respondent:
David M. Gould, Esq.

Administrative Magistrate:
Yakov Malkiel

SUMMARY OF RECOMMENDED DECISION

Discipline may be imposed on the respondent physician for an array of reasons. They include his habitual failure to consult a state database before prescribing benzodiazepines, his deceitful bills to insurers, and his incomplete licensing applications.

RECOMMENDED DECISION

The Board of Registration in Medicine commenced disciplinary proceedings against respondent Lee S. Altman, M.D., and referred the case to DALA. Administrative Magistrate Angela McConney held a five-day evidentiary hearing during April-May 2022. She admitted exhibits marked 1-115 into evidence. Competing expert opinions were offered by Dr. Miles Cunningham (for the board) and Dr. Allan Nineberg (for Dr. Altman). Other witnesses were Dr. Manuel Pacheco, Tina Duong, Erica Tillier, David Johnson, and Dr. Altman himself.[1]

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[1] Upon Magistrate McConney's appointment to the Civil Service Commission, the parties agreed not to repeat the evidentiary hearing, and the case was reassigned. *See* 801 C.M.R. § 1.01(11)(e).

FINDINGS OF FACT

I find the following facts.

I. Background

1. Dr. Altman graduated from medical school in 1991. He is licensed to practice medicine in Massachusetts under certificate number 80696. He specializes in psychiatry. (Answer ¶ 1; 2 Tr. 132, 153-154.)

2. From approximately 2006 through 2012, Dr. Altman was employed by Harvard Vanguard Medical Associates. He now maintains a busy private practice in Stoughton. (Answer ¶¶ 1, 2, 9; 2 Tr. 146-154; 3 Tr. 44, 189; 5 Tr. 15-16, 53-54.)

II. Diagnosis and Treatment of Patient B

3. *Bipolar diagnosis*. Dr. Altman treated Patient B in private practice from G.L. c. 4, § 7(26)(c) 2014 through G.L. c. 4, § 7(26)(c) 2019. Her original reported symptoms included G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c), G.L. c. 4, § 7(26)(c). Dr. Altman diagnosed Patient B as being "in the bipolar spectrum." (Answer ¶ 29; Exhibit 103; 1 Tr. 45-49, 59, 127; 3 Tr. 45-58.)

4. Dr. Altman stood by his original diagnosis throughout the course of his care for Patient B. He relied on the following considerations: A number of Patient B's symptoms were among the usual diagnostic criteria for bipolar spectrum. Patient B reported a G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c). Her reported G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c) And a series of G.L. c. 4, § 7(26)(c) did not improve her condition. Dr. Altman also observed that a prior

provider had prescribed a G.L. c. 4, § 7(26)(c) to Patient B.[2] (Answer ¶ 31; Exhibit 103; 1 Tr. 47-49, 124-134; 3 Tr. 46-58, 69-70, 83, 90; 4 Tr. 19-21, 111-112.)

5. The DSM-5 discusses a number of "bipolar and related disorders." It states that at least some of the disorders in that category may be diagnosed only if the patient has exhibited at least three manic symptoms for at least four days. Manic symptoms include grandiosity, decreased need for sleep, pressured speech, flight of ideas, distractibility, agitation, and high-risk behaviors. Patient B did not report or display such symptoms. (Answer ¶ 32; Exhibits 93, 103, 109; 1 Tr. 49-67, 145; 3 Tr. 49-50; 4 Tr. 117.)

6. Complaint counsel contends that Dr. Altman's diagnosis was inconsistent with the DSM-5. But at the hearing, board expert Dr. Cunningham acknowledged that a bipolar diagnosis may satisfy the standard of care even in the absence of manic symptoms—*if* the treating physician promptly monitors, over the course of 4-8 weeks, whether the patient responds to a mood stabilizer. Dr. Altman did not adjust his diagnosis even though Patient B's G.L. c. 4, § 7(26)(c) [redacted] He therefore did not find their ineffectiveness to be instructive. This explanation is reasonable. (Exhibits 20, 99, 103; 1 Tr. 49-67, 145; 3 Tr. 49-50, 65-68, 71-78; 4 Tr. 23-24.)

7. G.L. c. 4, § 7(26)(c) *dosage*. As of January 2015, Patient B's medications G.L. c. 4, § 7(26)(c) [redacted] Originally, she took that medication G.L. c. 4, § 7(26)(c) [redacted] Dr. Altman instructed her to G.L. c. 4, § 7(26)(c) , G.L. c. 4, § 7(26)(c) [redacted]

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[2] After the hearing, Dr. Altman was permitted to serve a subpoena on a physician who treated Patient B after she left Dr. Altman's care. The subpoena was quashed when Patient B invoked the psychotherapist-patient privilege. G.L. c. 233, § 20B. I do not draw any factual inferences from that invocation. *See generally* Mass. Guide Evid. § 525(a).

[redacted]. G.L. c. 4, § 7(26)(c) [redacted]. (Exhibits 20, 103; 3 Tr. 69-72.)

8. Complaint counsel maintains that Dr. Altman engaged in improper prescribing practices by issuing two instructions that neutralized each other. When asked about Dr. Altman's strategy, Dr. Cunningham said, "I don't understand it." But Dr. Altman provided a reasonable explanation. By instructing Patient B G.L. c. 4, § 7(26)(c) he intended to improve the tolerability of her G.L. c. 4, § 7(26)(c) Medications taken at G.L. c. 4, § 7(26)(c) [redacted] Dr. Altman G.L. c. 4, § 7(26)(c) [redacted] (Exhibits 20, 99, 103; 3 Tr. 71; 4 Tr. 29.)

9. [redacted] *dosage*. In [redacted] 2015, Dr. Altman started Patient B on G.L. c. 4, § 7(26)(c) [redacted]. His thinking was apparently that Patient B was not achieving improvement on [redacted] Dr. Altman started Patient B G.L. c. 4, § 7(26)(c) [redacted]. He then G.L. c. 4, § 7(26)(c) [redacted]. (Answer ¶¶ 42, 45; Exhibits 20, 103; 1 Tr. 76, 151; 3 Tr. 72-73.)

10. Complaint counsel maintains that Dr. Altman's acceleration of Patient B's G.L. c. 4, § 7(26)(c) [redacted]. By a preponderance of the evidence, I do not so find. Patient B's G.L. c. 4, § 7(26)(c) [redacted]. Complaint counsel has not explained why similar increases would be inappropriate for patients with related disorders. (Exhibits 20, 99, 103, 110; 1 Tr. 78; 3 Tr. 73-75; 4 Tr. 28; 5 Tr. 130-132.)

11. G.L. c. 4, § 7(26)(c) Patient B began taking the G.L. c. 4, § 7(26)(c) 2014. G.L. c. 4, § 7(26)(c), G.L. c. 4, § 7(26)(c) I do not find that this aspect of Dr. Altman's care for Patient B violated the standard of care. (Exhibits 20, 99, 103; 1 Tr. 102-104; 3 Tr. 114-118; 4 Tr. 32-33, 128.)

12. In G.L. c. 4, § 7(2 2019, Patient B admitted to Dr. Altman that she was G.L. c. 4, § 7(26)(c) . Dr. Altman proposed to G.L. c. 4, § 7(26)(c) (Exhibit 103; 3 Tr. 118-124; 4 Tr. 47-48; 5 Tr. 112-115.)

13. During the following month, Patient B complained to Dr. Altman of G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c). She was still in the process of tapering her G.L. c. 4, § 7(26)(c). Dr. Altman prescribed the G.L. c. 4, § 7(26)(c). By a preponderance of the evidence, I find that this decision was medically inappropriate. Dr. Altman explained that he intended to continue taking Patient B off G.L. c. 4, § 7(26)(c) while getting her "back on track." Undoubtedly he meant well. But Dr. Cunningham opined persuasively that, at this juncture, Dr. Altman's decision to prescribe G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c) —did not adequately account for Patient B's G.L. c. 4, § 7(26)(c) G.L. c. 4, § 7(26)(c). On this particular point, Dr. Nineberg's opinion was ambiguous. (Exhibits 20, 99 103; 1 Tr. 108-109; 3 Tr. 126-129; 4 Tr. 47-48; 5 Tr. 115-118.)

14. *Record keeping*. Dr. Altman used a standard SOAP format (Subjective, Objective, Assessment, Plan) to document his care of Patient B. To prepare his records, he relied on a "copy forward" function that repopulated new notes with information from previous visits. This practice frequently caused excessive repetition. It sometimes produced outright errors. On some occasions, Dr. Altman likely restated prior observations instead of offering subtly updated assessments. (Answer ¶ 64-69; Exhibits 20, 90, 103; 1 Tr. 112-13; 3 Tr. 132-141; 4 Tr. 34-35; 5 Tr. 118-120.)

15. Even so, I do not find that Dr. Altman's records of his care for Patient B fell below the standard of care. "Copy forward" mechanisms are ubiquitous in today's medical recordkeeping. Their downsides and dangers are clear and commonplace. The evidence does not indicate that Dr. Altman's records suffered appreciably more from these problems than is normal. On the whole, his notes were reasonably complete and up-to-date. Two of the three experts to address the quality of Dr. Altman's records[3] saw them as consistent with the standard of care. (Exhibits 20, 90, 99, 103; 1 Tr. 152; 4 Tr. 34-35, 60-66.)

III. PMP Usage Issues

16. The Prescription Monitoring Program (PMP) is a list of certain prescriptions filled at pharmacies. It may be accessed online through the Massachusetts Prescription Awareness Tool (MassPAT). Since December 2014, DPH regulations have required physicians to consult the PMP before prescribing benzodiazepines to patients for the first time. Even Dr. Nineberg recognized that "it is standard practice to check the PMP before prescribing controlled substances" (though he opined that this practice is sometimes difficult to maintain). (Answer

[3] Concerning Patient A, in the case of Dr. Sorrentino (a non-testifying board expert).

¶ 18; Exhibits 91, 99; 2 Tr. 8-11; 4 Tr. 85; 5 Tr. 97, 125-126, 132-133; 105 C.M.R. § 700.012(G).)

17. Dr. Altman did not find the PMP to be helpful. He estimated that, as of late 2017, he was using the PMP "50 to 75 percent of the time." On various dates between November 2015 and November 2018, Dr. Altman prescribed benzodiazepines to Patients A-D and G-L without first consulting the PMP. At least in the cases of Patients C, D, and G, the PMP would have disclosed information about the patients' prior use of prescription benzodiazepines. (Exhibits 28-45, 49-66, 91, 104, 105; 2 Tr. 10, 20-22, 117-119, 127-128, 177; 3 Tr. 19-37, 172-173; 4 Tr. 42-44; 5 Tr. 133-136, 150-151.)[4]

18. Specific medical considerations called for Dr. Altman to consult the PMP before prescribing benzodiazepines to Patients C and D. The history Dr. Altman took from Patient C indicated prior G.L. c. 4, § 7(26)(c) [5] And Dr. Altman acknowledged in a note on his prescription to Patient D, "G.L. c. 4, § 7(26)(c) " (G.L. c. 4, § 7(26)(c)). (Answer ¶ 80; Exhibits 11, 12, 26, 29-36, 43-45, 104; 2 Tr. 16-35, 105-111, 128-129; 3 Tr. 163; 5 Tr. 78-83, 136-137.)

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[4] Patients D, E, F, G, J, K, L, and M apparently died of causes related to substance abuse or intoxication. These sad deaths would have been highly relevant to this matter if complaint counsel had alleged and attempted to prove that the deaths were caused by Dr. Altman's conduct. In the absence of such allegations and proof, the facts of the patients' deaths amount to innuendo bearing obvious potential for unfair prejudice. *See generally* Mass. Guide Evid. § 403 (2023); *United States v. Cadden*, 965 F.3d 1, 21-22 (1st Cir. 2020); *United States v. Mello*, No. 20-cr-72, 2023 WL 4868305, at *7-8 (D. Me. July 31, 2023).

[5] Dr. Altman consulted the PMP several hours after Patient C left his office. At an interview with board staff, he stated that he then called Patient C's pharmacy and her other doctor. I am not persuaded that any inaccuracies in his account were intentional or material. The record also does not establish that Dr. Altman's prescriptions to Patient C were medically inappropriate. (Exhibits 25-34; 2 Tr. *passim*; 3 Tr. 160-182.)

19. In May 2018, the board notified Dr. Altman that it was investigating him in connection with the deaths of Patients D, E, F, and G. Soon thereafter, Dr. Altman looked up those patients on the PMP. A list of terms and conditions presented to prescribers who log into the PMP states, in part: "You attest that your use of the [PMP] is for evaluating and prescribing and/or dispending . . . a controlled substance . . . . You attest that use of the [PMP] is for the purpose of preventing the prescribing and/or dispensing of controlled substances to the same individual from multiple sources or the unlawful diversion of controlled substances." (Exhibits 14, 45, 48, 51, 66-70, 89, 91; 3 Tr. 24-26, 207-209; 5 Tr. 34-35, 137-140.)

IV. Billing Issues

20. *Patient A*. Dr. Altman treated Patient A for approximately 3.5 months during 2015-2016. During that span, Patient A missed five scheduled appointments. Each time, Dr. Altman billed her insurance company as if the appointment had taken place. I find that Dr. Altman knew that he was billing Patient A's insurer for appointments that did not occur. Dr. Altman asserts that, on busy days, it was his practice to prepare insurance claims before he commenced his work. But it is not likely that he failed to notice—five times—that the same patient kept failing to appear, he kept submitting his bills, and he kept getting paid.[6] (Answer ¶¶ 11-16; Exhibits 10, 16-18; 5 Tr. 61-63.)

21. *Patient M*. Dr. Altman began to treat Patient M in G.L. c. 4, § 7(26)(c) 2017. He failed to preserve medical records for two of Patient M's subsequent appointments. Patient M was scheduled to see Dr. Altman on G.L. c. 4, § 7(26)(c) 2018. The appointment did not take place because

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[6] In light of the parties' agreement not to repeat the evidentiary hearing, this decision's determinations about the credibility of certain of Dr. Altman's claims rely on circumstances other than his observable demeanor. *Cf. Lighthouse Masonry, Inc. v. Division of Admin. L. Appeals*, 466 Mass. 692, 705 n.23 (2013).

Patient M had died by then. Dr. Altman nonetheless prepared a note of an [redacted] 2018 session with Patient M, and proceeded to bill Patient M's insurer. By a preponderance of the evidence, I find that Dr. Altman prepared these untrue records while knowing that his session with Patient M did not take place. It is too difficult to believe that a physician would inadvertently prepare a treatment note about a nonexistent meeting. (Answer ¶¶ 154, 160-163; Exhibits 78, 82, 83, 96; 3 Tr. 207; 4 Tr. 143-148; 5 Tr. 120-125, 152-153.)

22. *Patients N and O.* Dr. Altman billed Patient N's insurer for two appointments during 2014 but failed to preserve records of those appointments. He billed Patient O's insurer for one appointment during 2015 but failed to preserve records of that appointment. (Answer ¶¶ 164-169; 3 Tr. 203-206; 5 Tr. 123-124, 148-150.)

23. *Various patients*. On approximately 15-20 occasions, Dr. Altman received notices from substance-abuse clinics stating that one of his patients had failed a urine toxicology screen. After receiving such notices, Dr. Altman generally terminated his relationships with the pertinent patients. He would retain the notices in the patients' files for approximately three to six months, then shred them. (Answer ¶¶170-176.)

V. Statements on Board Applications

24. As of 2012, Dr. Altman was still working for Harvard Vanguard. In February of that year, he was terminated from his position. The termination letter stated that Dr. Altman had failed to properly code and document his patient encounters. The letter also cited concerns about Dr. Altman's "patient volume," "patient interactions," and "length of patient visits." Dr. Altman pursued an unsuccessful appeal with Harvard Vanguard from its original termination decision. (Answer ¶¶ 2-8; Exhibits 1-7; 3 Tr. 199-200; 5 Tr. 16-34.)

25. In January 2013, Dr. Altman submitted an application to renew his medical license. He answered [redacted] to each of the following questions:

[redacted]

(Answer ¶ 10; Exhibit 8; 3 Tr. 209-210; 5 Tr. 52-55.)

26. I find that Dr. Altman understood that his termination was a "disciplinary action" taken against him by a "health care facility." His contrary position is implausible. [redacted] (Exhibits 1, 2, 7; 3 Tr. 202, 211-216; 5 Tr. 16-40, 55-59, 143.)[7]

27. In May 2018, the board issued a notice to Dr. Altman stating that he was the subject of an open board investigation. Dr. Altman responded to that notice soon thereafter. In January 2019, he completed a license renewal application, answering [redacted]" to the question, [redacted] . . . ?" It is not plausible that he did not believe then that he was under investigation. (Answer ¶¶ 180-183; Exhibit 14, 15, 19; 5 Tr. 64-68.)

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[7] Dr. Altman disputes the merits of Harvard Vanguard's concerns about this work. But those merits are irrelevant to the board's allegation, which is that Dr. Altman should have informed the board of the disciplinary action against him.

28. During July 2019, law enforcement personnel executed a search of Dr. Altman's office. In January 2021, he completed a license renewal application. He answered "[redacted]" to the question, [redacted] . . . ?" The instructions to the application form required applicants to complete a separate "Form R" with respect to each "[redacted]" answer. Dr. Altman did not complete a "Form R" or provide the board with any additional information—other than his "[redacted]" answer—about his ongoing investigations. He signed the application and declared under the penalties of perjury that the information contained in it was accurate and complete. (Answer ¶¶ 185, 187-191; Exhibits 80, 81, 100; 2 Tr. 136; 5 Tr. 65-73, 144-146.)

RULINGS OF LAW

Complaint counsel bears the burden of proving the alleged predicates for discipline by a preponderance of the evidence. *See Welter v. Board of Registration in Med.*, 490 Mass. 718, 721 (2022); *Craven v. State Ethics Comm'n*, 390 Mass. 191, 200-01 (1983). That burden is satisfied here as to an array of statutory, regulatory, and common law predicates. The following paragraphs elaborate, reordering the board's theories for convenience.

I. Specific Regulations Relating to the Practice of Medicine (Basis for Relief C)

The board is authorized to discipline a physician who "is guilty of an offense against any provision of the laws of the commonwealth relating to the practice of medicine, or any rule or regulation adopted thereunder." G.L. c. 112, § 5, 8th para., (b). A regulation requiring physicians to consult the PMP in various circumstances is codified at 105 C.M.R. § 700.001(G)(1). Those circumstances include "prior to prescribing . . . a benzodiazepine." § 700.001(G)(1)(b). The regulation was promulgated by DPH under the authority of the statute that establishes the PMP. G.L. c. 94C, § 24A.

These regulation and statute obviously relate to the practice of medicine. Dr. Altman admits that he frequently failed to comply with the regulation's demands. He specifically failed to consult the PMP before first prescribing benzodiazepines to Patients A-D and G-L. This repeated transgression warrants discipline. *See In the Matter of Sauls*, No. 2021-045 (BORIM Nov. 4, 2021) (consent order); *In the Matter of Abramson*, No. 2021-043 (BORIM Nov. 4, 2021) (consent order).[8]

II. Deceit and Misconduct in the Practice of Medicine (Bases for Relief F, G, and H)

Under a statute applicable to multiple licensing agencies, the board may discipline a physician who has "engaged in dishonesty, fraud or deceit which is reasonably related to the practice of the profession." G.L. c. 112, § 61. A specific board regulation also authorizes discipline for "[p]racticing medicine deceitfully, or engaging in conduct which has the capacity to deceive or defraud." 243 C.M.R. § 1.03(5)(a)(10).

Dr. Altman billed Patient A's insurer for five appointments that did not happen over a 3.5-month span. *Cf. Fisch v. Board of Registration in Med.*, 437 Mass. 128, 129, 134 (2002). He prepared a treatment note and submitted a bill in connection with a session with Patient M that also did not occur. The Supreme Judicial Court has made clear that such actions are within the scope of a physician's practice of medicine, because "[t]he practice of modern medicine

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[8] The statement of allegations does not allege a violation of the regulation requiring physicians to maintain "a medical record for each patient that is complete, timely, legible, and adequate to enable the licensee or any other health care provider to provide proper diagnosis and treatment." 243 C.M.R. § 2.07(13)(a). The statement of allegations does allege that Dr. Altman violated a board "policy" about "disruptive physician behavior." This policy may or may not count as a "rule or regulation." *See In the Matter of Schwartz*, No. RM-15-648, at *14-15, 23 (DALA Dec. 29, 2020); *In the Matter of Bock*, No. RM-14-16, at *21 (DALA July 16, 2018). In any event, a preponderance of the evidence does not support the pertinent factual allegations, which revolve around Patient A's dissatisfaction with Dr. Altman's demeanor.

involves financial management, as well as the care and treatment of patients." *Levy v. Board of Registration & Discipline in Med.*, 378 Mass. 519, 526-27 (1979). This is true in part because the availability of medical care now often depends on insurance-related arrangements. *Id. See also Feldstein v. Board of Registration in Med.*, 387 Mass. 339, 341 (1982).

The applicable statute and regulation speak subjunctively of "dishonesty," "fraud," and "deceit." The finding of fact that Dr. Altman knew that his pertinent sessions with Patient A and Patient M did not occur means that all three of these rubrics apply. *See supra* pp. 8-9; *Fisch*, 437 Mass. at 139.[9] The same finding means that Dr. Altman's behavior was "willed and intentional . . . wrongdoing," *Hellman v. Board of Registration in Medicine*, 404 Mass. 800, 804 (1989), and therefore "misconduct" in the practice of medicine within the meaning of 243 C.M.R. § 1.03(5)(a)(18). Discipline is warranted on these bases.

III. Deficient Reporting to the Board (Bases for Relief I and J)

The board may discipline a physician for a "[f]ailure to report to the Board . . . any disciplinary action taken against the licensee . . . by any health care institution . . . by any governmental agency, [or] by any law enforcement agency . . . for acts or conduct substantially the same as acts or conduct which would constitute grounds for complaint [under the board's regulations]." 243 C.M.R. § 1.03(5)(a)(15). *See BORIM v. Pfannl*, No. RM-17-988, at *19-20 (DALA Nov. 25, 2019, *adopted*, BORIM Nov. 19, 2020).

[9] Dr. Altman's bills for sessions that did not occur would amount to "deceit" even if they were unintentional. In the context of the board's regulations, "deceit" is not tethered to the traditional concept of "fraud," and thus "do[es] not necessarily depend on intent, knowledge, materiality, or reliance." *Welter*, 490 Mass. at 727.

In 2012, Dr. Altman's employing institution disciplined him based on alleged deficiencies relating to coding, documentation, patient volume, patient interactions, and patient visit length. He did not disclose this action in his 2013 renewal application. In 2018, board staff informed Dr. Altman that he was under investigation. He did not include this information in his January 2019 renewal application. In July 2019, law enforcement personnel executed a search of Dr. Altman's office. He did not provide any specifics about this occurrence in his 2021 renewal application.

Dr. Altman apparently concedes that these investigations all involved the types of issues that would support complaints to the board. His failure to disclose the pertinent details on his renewal applications warrants discipline.[10]

IV. Competence to Practice Medicine (Basis for Relief A)

The board may discipline "conduct which places into question the physician's competence to practice medicine." G.L. c. 112, § 5, 8th para., (c). Standing alone, this phrase's elasticity might make it difficult to apply predictably. But the governing statute also offers examples of the conduct that the Legislature had in mind, namely: "gross misconduct in the practice of medicine or . . . practicing medicine fraudulently, or beyond its authorized scope, or

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[10] The record does not establish that Dr. Altman "fraudulently procured" his registration renewals. G.L. c. 112, § 5, 8th para., (a). *See* 243 C.M.R. § 1.03(5)(a)(1). Unlike terms such as "deceit," "fraudulent procurement" evokes the classic elements of common law fraud. *Welter*, 490 Mass. at 727. These elements include "reliance," meaning that the deceived person must have "relied upon the representation as true and acted upon it." *Id.* at 725 (quoting *Masingill v. EMC Corp.*, 449 Mass. 532, 540 (2007)). The record does not indicate whether the board would have been materially less likely to renew Dr. Altman's license if his applications had been complete. On the other hand, it may be that Dr. Altman's deficient applications amounted to "[f]ailure . . . to furnish the Board . . . information . . . to which the Board is legally entitled." 243 C.M.R. § 1.03(5)(a)(16). *Cf. BORIM v. Pfannl*, *supra*, at *20-21.

with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions." *Id.* *See* 243 C.M.R. § 1.03(5)(a)(3).

Dr. Altman's competence to practice medicine is placed into question by his "negligence on repeated occasions."[11] Most of complaint counsel's negligence-oriented theories focus on Dr. Altman's care for Patient B. With respect to that relationship, Dr. Altman's only proven negligence concerns his choice to prescribe Ambien to Patient B on the heels of her suicidal ideation and drug abuse. *See supra* p. 5. But Dr. Altman also committed repeated, habitual negligence by failing to refer to the PMP before prescribing benzodiazepines to his patients. Dr. Altman's own expert conceded that this conduct contravened "standard practice." And the board has previously deemed failure to consult the PMP to be disciplinable negligence. *See Matter of Sauls*, *supra*.[12]

Dr. Altman's series of deceitful bills also amounted to negligence on repeated occasions. The Supreme Judicial Court has stated specifically that such transgressions "reflect[] adversely on a physician's fitness to practice medicine." *Levy*, 378 Mass. at 527. Dr. Altman's competence to practice is therefore drawn into question on this basis as well.

V. Undermining the Integrity of the Profession (Basis for Relief E)

Levy, *supra*, and *Raymond v. Board of Registration in Med.*, 387 Mass. 708 (1982), stand for the proposition that "lack of good moral character and conduct that undermines public

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[11] To count as "gross," negligence or incompetence must be "flagrant and extreme." *Hellman*, 404 Mass. at 804. To the extent that the board intended to attribute such conduct to Dr. Altman, the evidence does not support that charge.

[12] Dr. Altman's repeated negligence did not amount to "malpractice." G.L. c. 112, § 61; 243 C.M.R. § 1.03(5)(a)(17). Malpractice requires proof that the negligent conduct proximately caused harm to patients. *See In the Matter of Aweh*, No. 2019-040, at *2 n.5 (BORIM Oct. 20, 2022). That causal link is unproven here.

confidence in the integrity of the medical profession are grounds for discipline." *Raymond*, 387 Mass. at 713. This standard is especially nebulous. Its application is fraught with the potential for unfair surprise. *See Pedro v. BORIM*, No. RM-18-622, at *5-6 (DALA June 28, 2021, *adopted*, BORIM Dec. 16, 2021). The ubiquity of charges based on *Levy* and *Raymond* in the board's practice is therefore discomforting. *Id.*

Even so, it is clear that *Levy* and *Raymond* support the imposition of discipline in this case. *Levy* itself authorized discipline based on "intentional misdeed[s] relating to third-party payors." 378 Mass. at 527. In Dr. Altman's case, such misdeeds are supplemented by his series of deceitful bills, his several unforthcoming renewal applications, and his PMP inquiries about Patients D, E, F, and G after their deaths, when they were no longer his patients. *Cf. In the Matter of Riella*, No. 2020-049 (BORIM June 30, 2022); *In the Matter of August*, No. 2009-015 (BORIM May 20, 2009) (consent order). Taken together, these actions clearly establish a *Levy-Raymond* predicate for discipline.

CONCLUSION

The board may impose disciplinary measures on Dr. Altman in connection with the bases for discipline described *supra*.

Division of Administrative Law Appeals

/s/ Yakov Malkiel
Yakov Malkiel
Administrative Magistrate