

**Before the  
New Hampshire Board of Medicine  
Concord, New Hampshire 03301**

**In The Matter Of:**

**Docket No.: 11-06**

**Susan M. Hare, M.D.**

License No.: 11415

(Adjudicatory/Disciplinary Proceeding)

**FINAL DECISION AND ORDER**

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding of Susan M. Hare, M.D. ("Respondent" or "Dr. Hare").

**Background Information:**

On or about February 21, 2011, the Board received information from the media that the Respondent's medical practice, Riverfront Medical Group ("Riverfront"), had closed. The Respondent was alleged to have closed her practice without providing notice to patients or staff. On March 21, 2011, the Board issued a Notice of Hearing. The hearing was originally scheduled on April 6, 2011. On March 28, 2011, the Respondent, through an attorney, filed a motion to continue. On April 1, 2011, the presiding officer issued a written order continuing the hearing to June 1, 2011.

On Wednesday, June 1, 2011, at 3:00 p.m., the Board commenced with the adjudicatory/disciplinary hearing in the above captioned matter. Board members present<sup>1</sup> were:

Gail Barba, Public Member, Presiding Officer  
Robert Andelman, Physician Member, Chair  
Nick Perencevich, Physician Member  
John Wheeler, Physician Member  
Mark Sullivan, Physician Assistant Member  
Edmund Waters, Jr., Public Member  
Robert Vidaver, Physician Member  
Daniel Morrissey, Public Member

The prosecution was represented by Hearing Counsel Attorney Sarah Blodgett of the Administrative Prosecutions Unit ("APU") of the Office of the Attorney General. No counsel has filed an appearance in the above captioned matter, docket #11-06.<sup>2</sup> Neither the Respondent nor a representative

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<sup>1</sup> These same Board members also deliberated and voted on this Final Decision and Order except for Vidaver and Morrissey who were absent for the final vote.

<sup>2</sup> At the hearing, Attorney Blodgett informed the Board that Attorney Bartholomew, who had represented the Respondent in previous matters before the Board (docket #s 10-03, 11-01, and 11-04) and who had filed the motion to continue, informed Attorney Blodgett that he was not representing the Respondent in the docket # 11-06 matter.

attended the hearing scheduled for June 1, 2011 at 3:00 p.m. The Board waited until 3:15 p.m. and then proceeded to hold the hearing in the Respondent's absence.

**Secondary Procedural Background:**

On September 8, 2010, the Board issued a Settlement Agreement in *In the Matter of Susan M. Hare*, docket number 10-03. See docket 10-03 Settlement Agreement dated 9/8/10. The Settlement Agreement resolved multiple complaints relating to the Respondent's pain management practice. In the Settlement Agreement, the Board issued disciplinary action including: (A) suspending the Respondent's license for 5 years, of which 2 were imposed; (B) indefinitely restricting the Respondent from prescribing schedule II and III narcotics; (C) permanently restricting the Respondent from treating chronic pain patients; (D) completing a program; (E) participating in 24 CMEs; and (F) assessing a \$5,000 fine.

On January 10, 2011, the Board issued a Notice of Hearing in docket number 11-01 pursuant to information that the Respondent failed to comply with the terms of the 9/8/10 Settlement Agreement by failing to pay the administrative fine. On February 4, 2011, the Board issued a Notice of Hearing in docket number 11-04 pursuant to information that the Respondent, who was acting as the director or office manager of the practice she owned – Riverfront, engaged in the practice of medicine while her license was under suspension. As stated above, on March 21, 2011, the Board issued the present Notice of Hearing (docket 11-06) pursuant to information regarding failure to alert patients and staff about closing Riverfront, failing to respond to patients' records requests, failing to safeguard patient information, and failing to cooperate with a Board investigation.

On April 6, 2011, the Board held a hearing in docket 11-01. On May 6, the Board issued an order finding the Respondent had, among other things, failed to pay her administrative fine; the Board fined her \$10,000. See Docket 11-01 Final Decision and Order dated 5/6/11. On April 6 and 15, 2011, the Board held a hearing in docket 11-04. On May 10, the Board issued an order finding

the Respondent had, among other things, practiced medicine while suspended; the Board revoked her license.<sup>3</sup> See Docket 11-04 Final Decision and Order dated 5/10/11.

**Findings of Fact:**

Hearing Counsel presented one witness, Dori Tohill, the Board's investigator. The Board found Tohill to be professional, forthright and credible. The following exhibits were introduced into evidence and accepted into the record:

- Hearing Counsel's exhibits<sup>4</sup>: 1 through 11.
- The Respondent's exhibits: None.

In light of the testimony and exhibits, the Board finds the following facts:

While maintaining investigative files in the adjudicatory/disciplinary proceedings of dockets 11-01 and 11-04, the Board's investigator learned on or about February 22, 2011, that the Respondent closed Riverfront the day before. The investigations had revealed that the Respondent was owing approximately eighty-thousand dollars (\$80,000) in back rent to Riverfront's landlord and that the Respondent was having difficulties paying her employees and that the Department of Labor became involved. The Board's prosecutor and the Respondent's then legal counsel discussed, orally and in email, Riverfront's patients' records. Exhibits 1-4. Among other things, the following issues were reviewed: (1) continuity of patient care; (2) maintenance of patient records; (3) maintaining confidentiality of patient records; and (4) providing medical records to patients within thirty days. Exhibits 1-4. Also reviewed was (5) the Respondent's failure to respond to a Board investigation/subpoena.

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<sup>3</sup> As the Respondent has held a valid license at all relevant points of time pertaining to this matter, the Board had the authority to pursue the investigation and has the authority to impose disciplinary sanctions. Appeal of Rowan, 142 N.H. 67, 75 (1997); cf. Med. 412.02 (c).

<sup>4</sup> Hearing Counsel provided the Board with a list of witnesses and exhibits on or about March 31, 2011. At that time, Hearing Counsel provided these documents to Attorney Bartholomew, who was representing the Respondent in dockets 11-01 and 11-04. Attorney Bartholomew notified Hearing Counsel that he would not represent the Respondent in the current matter. He also stated that he would forward the documents to the Respondent. There is no confirmation that she received these documents. However, shortly thereafter, Hearing Counsel mailed these documents to the Respondent by certified mail. As the crux of the matter involved the Respondent's close of practice, the documents were mailed to her home. The certified mail was refused at that address. Thereafter, Hearing Counsel mailed these documents to the Respondent's home via regular first class mail. These documents have not been returned. The Board's administrative rules require licensees to maintain their current home and work addresses on file with the Board's office. See Med 403.02. The presumption is, and the Board finds, that the Respondent has received these documents.

(1) Continuity of Patient Care:

On February 22, 2011, the Respondent, through her counsel<sup>5</sup>, informed Hearing Counsel that the Respondent had made arrangements for the continuity of patient care. Exhibit 1. The Respondent asserted that Dr. Peter Loeser and ARNP Pam Williams would be taking over the Respondent's practice in as much as they could be contacted to provide refills for active prescriptions. Exhibit 1<sup>6</sup>. Hearing Counsel's Investigator, Todd Flanagan, spoke to Dr. Loeser who stated that the Respondent never asked him to cover for refills for her patients. Exhibit 2<sup>7</sup>. Indeed, neither Dr. Loeser nor Nurse Williams were available to refill the Respondent's patients' prescription refills. Thus, the Respondent's assertions regarding the continuity of patient care were misleading and erroneous.

The Respondent, through her counsel<sup>8</sup>, also informed Hearing Counsel that she would draft and send a letter to all active patients. Exhibit 1<sup>9</sup>. The Respondent asserted that she would provide her personal/home telephone number for patients. Exhibit 1<sup>10</sup>. The Respondent, however, never sent such a letter. Moreover, her office telephone number was disconnected. While it does appear that the Respondent did maintain the office fax number after Riverfront closed, it is unclear that she has responded to any faxes from patients. Thus, the Respondent's assertions regarding the ability of patients to contact her regarding the continuity of care or records requests was misleading and erroneous.

(2) Maintenance of Patient Records:

On February 22, 2011, the Respondent, through her counsel, informed Hearing Counsel that the Respondent had made arrangements for the maintenance of patient records. Exhibit 1.

I have been given the following information to pass along:  
Currently, the medical records from the practice are either (1) scanned into the electronic medical records system for the practice, Practice Fusion ([www.practicefusion.com](http://www.practicefusion.com)), (2) are

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<sup>5</sup> Exhibit 1: "I have been given the following information to pass along."

<sup>6</sup> Exhibit 1: "Dr. Peter Loeser and ARNP Pam Williams can be contacted to provide refills for active prescriptions."

<sup>7</sup> Exhibit 2: "Dr. Hare did not make any arrangements with Dr. Loeser to provide coverage to patients."

<sup>8</sup> Exhibit 1: "I have been given the following information to pass along."

<sup>9</sup> Exhibit 1: "Dr. Hare is preparing a letter to those patients that she can identify as active."

<sup>10</sup> Exhibit 1: "[H]er personal number will be provided in the letter to active patients and it is in the phone book."

at Dr. Hare's home being scanned into the EMR system, or (3) in locked storage at Belmont Self-Storage (a unit has been rented and is being used). Dr. Hare has the capability to scan medical records at her home, and has given priority to scanning and sending out those records that have been requested already and second priority for active patients. Her plan is to complete scanning all records, with non-active patient records and records for patients who requested their records be sent elsewhere prior to the implementation of the Practice's EMR system, to be scanned last. Once records have been scanned and the upload to the EMR system confirmed, the records will be shredded at Dr. Hare's house and her plan is to then have the shredded records incinerated.

Exhibit 1. The Respondent, however, would not confirm any of this information. Exhibits 2, 3, and 4. There is no corroboration that medical records are being electronically scanned into Practice Fusion or the EMR system. There is no evidence that patients' private medical records are being maintained securely in the self-storage locker. To the contrary, there is ample evidence that the Respondent has not done so as detailed in the following section.

(3) Maintaining Confidentiality of Patient Records:

On February 23, 2011, the Board's Investigator went to Riverfront to assess the practice's closure. Adjacent to the building were piles of trash, some in bags. Exhibit 5 and 6. This pile was accessible to anyone. Exhibit 6. The Investigator found portions of patients' medical records in at least one bag. The documents that the Investigator found are included in Exhibit 9<sup>11</sup>.

Exhibit 9 includes SOAP<sup>12</sup> notes with the patients' names and dates of birth in plain sight. These privileged patients' medical records are replete with information that, if found by a third-party, would have constituted an invasion of these patients' privacy. E.g. Exhibit 9, pages 7, 8, 9, 13, 18, 19, 20, 48, 52, and 64. This exhibit contains information about patients which are not only extremely private and personal but also potentially harmful to their reputations. E.g. Exhibit 9, pages 7, 46, and 48.

Exhibit 9 includes confidential patient records, which include the name and date of birth of:

- PL (page 2; Notice of Hearing paragraph 6J); 1
- AJ (page 3; Notice of Hearing paragraph 6K); 2
- JK (page 4; Notice of Hearing paragraph 6L); 3

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<sup>11</sup> Hearing Counsel has redacted the private information for the Board's records; however, the documents the investigator found, and which Hearing Counsel maintains, are unredacted.

<sup>12</sup> SOAP is an acronym for Subjective, Objective, Assessment, and Plan.

• LG (page 6-7; Notice of Hearing paragraph 6M);	4
• RJ (page 8; Notice of Hearing paragraph 6N);	5
• JA (page 9; Notice of Hearing paragraph 6O);	6
• CB-F (page 10-11; Notice of Hearing paragraph 6P);	7
• JP (page 12; Notice of Hearing paragraph 6Q);	8
• TV (page 13; Notice of Hearing paragraph 6R);	9
• DP (page 14; Notice of Hearing paragraph 6S);	10
• JW (page 15-16; Notice of Hearing paragraph 6U);	11
• KM (KFM) (page 17-44; Notice of Hearing paragraph 6V);	12
• DM (page 45; Notice of Hearing paragraph 6W);	13
• DG (page 46-48; Notice of Hearing paragraph 6X);	14
• PR (page 49; Notice of Hearing paragraph 6Y);	15
• KB (page 50-52; Notice of Hearing paragraph 6Z);	16
• JN (page 53-54; Notice of Hearing paragraph 6AA);	17
• SB (page 62; Notice of Hearing paragraph 6BB);	18
• GC (page 64; Notice of Hearing paragraph 6CC); and	19
• SR (page 63; Notice of Hearing paragraph 6DD).	20

The Board finds<sup>13</sup> that the Respondent failed to safeguard these twenty (20) patients' confidential patient information.

Exhibit 9 includes computer printouts of "Patient Sign In" logs. Exhibit 9. These log documents include patients' names, their phone numbers and their dates of birth. Exhibit 9 (pages 1, 5; Notice of Hearing paragraph 6EE). The Board finds that the Respondent failed to safeguard patient information on patient sign-in sheets.

(4) Providing Patient Medical Records:

Subsequent to the closure of Riverfront, Board's Investigator learned that the Respondent did not give advance notice to the Riverfront staff (the Respondent's employees) that Riverfront would be closing. The Board finds<sup>14</sup> that the Respondent failed to alert staff to the possibility of the practice's closure. The investigation also revealed that the Respondent did not give advance notice

<sup>13</sup> (1) Paragraph 6T of the Notice of Hearing, charges the Respondent for failing to safeguard IM's confidential patient information. However, Exhibit 9 does not contain such records, thus the Board is not making a finding as to IM. (2) Exhibit 9 contains the confidential medical record of AJ (at pages 55-61). However, it is unclear whether this is the same AJ contained in paragraph 6K of the Notice of Hearing, thus the Board is not making a finding as to these pages.

<sup>14</sup> Notice of Hearing, paragraph 6B.

to Riverfront's patients that their medical office would be closing. The Board finds<sup>15</sup> that the Respondent failed to alert patients of the possibility of the practice's closure.

Patient LD:

On or about September 3, 2010, patient LD asked for a copy of his<sup>16</sup> medical records. Exhibit 8, page 4. Patient LD made several requests to the Respondent and/or her office staff for his medical records since that time. Exhibit 8, page 4. On February 16, 2011, the Board received a written complaint from LD regarding the Respondent's failure to provide him with his medical record. Exhibit 8, page 4. On February 23, 2011, the Board's Investigator issued a Subpoena Duces Tecum for LD's medical records. Exhibit 8, page 3. On that date, the Board's Investigator also required a written response to LD's complaint. Exhibit 8, page 2. These two documents were sent via certified mail to the Respondent. Exhibit 8, page 1. The Respondent received the documents on February 24, 2011. To date, the Respondent has failed to provide LD with his records.<sup>17</sup> To date, the Respondent has failed to provide a written response to the Board's Investigator.<sup>18</sup> To date, the Respondent has failed to provide the Board's Investigator with LD's records under the subpoena.<sup>19</sup>

Patients JM and HM:

On or about January 15, 2011, JM asked for a copy of her<sup>20</sup> son's medical records, patient HM. Exhibit 10, page 4. On or about February 16, 2011, Patient JM asked for a copy of her medical records. Exhibit 10, page 6. Patient JM made several requests to the Respondent and/or her office staff and/or her attorney for JM's and HM's medical records since that time. Exhibit 10, page 4-8. On March 8, 2011, the Board received a written complaint from JM regarding the Respondent's failure to provide her with JM's and HM's medical records. Exhibit 10, page 4. On March 11, 2011, the Board's Investigator issued a Subpoena Duces Tecum for JM's and HM's medical records. Exhibit 10, page 3. On that date, the Board's Investigator also required a written response to JM's complaint. Exhibit 10, page 2. These two documents were sent via certified mail to the Respondent

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<sup>15</sup> Notice of Hearing, paragraph 6A.

<sup>16</sup> LD's gender is unknown. For clarity, LD will be referred to as male.

<sup>17</sup> Notice of Hearing, paragraph 6C.

<sup>18</sup> Notice of Hearing, paragraph 6I.

<sup>19</sup> Notice of Hearing, paragraph 6H.

<sup>20</sup> JM's gender is unknown. For clarity, JM will be referred to as female.

on March 11, 2011. Exhibit 10, page 1. To date, the Respondent has failed to provide JM with her medical records.<sup>21</sup> To date, the Respondent has failed to provide JM with HM's medical records.<sup>22</sup> To date, the Respondent has failed to provide a written response to the Board's Investigator.<sup>23</sup> To date, the Respondent has failed to provide the Board's Investigator with JM's and/or HM's records under the subpoena.<sup>24</sup>

Patient ATH (request by CH):

On or about January 15, 2011, CH asked for a copy of her<sup>25</sup> child's medical records, patient ATH. Exhibit 11, page 3. CH made several requests to the Respondent and/or her office staff and/or her attorney for ATH's medical records since that time. Exhibit 11, page 3. On March 9, 2011, the Board received a written complaint from CH regarding the Respondent's failure to provide her with ATH's medical records. Exhibit 11, page 3. On March 14, 2011, the Board's Investigator issued a Subpoena Duces Tecum for ATH's medical records. Exhibit 11, page 2. On that date, the Board's Investigator also required a written response to CH's complaint. Exhibit 11, page 1. To date, the Respondent has failed to provide CH with ATH's medical records.<sup>26</sup> To date, the Respondent has failed to provide a written response to the Board's Investigator.<sup>27</sup> To date, the Respondent has failed to provide the Board's Investigator with ATH's records under the subpoena.<sup>28</sup>

(5) Responding to Board Investigations/Subpoenas:

As stated in the previous section, three exhibits were introduced to show that on three separate occasions the Board sent the Respondent requests to provide written responses to complaints.<sup>29</sup> Exhibit 8 page 2; Exhibit 10, page 2; Exhibit 11, page 1. These exhibits also showed that on these three separate occasions the Board sent the Respondent Subpoenas for documents to

<sup>21</sup> Notice of Hearing, paragraph 6D.

<sup>22</sup> Notice of Hearing, paragraph 6E. (A scrivener's error is noted that this paragraph states HP instead of HM).

<sup>23</sup> Notice of Hearing, paragraph 6I.

<sup>24</sup> Notice of Hearing, paragraph 6H.

<sup>25</sup> CH's gender is unknown. For clarity, CH will be referred to as female and ATH as male.

<sup>26</sup> Notice of Hearing, paragraph 6G.

<sup>27</sup> Notice of Hearing, paragraph 6I.

<sup>28</sup> Notice of Hearing, paragraph 6H.

<sup>29</sup> RSA 329:18, VII: "The board may at any time require a licensee or license applicant to provide a detailed, good faith written response to allegations of possible professional misconduct or grounds for non-disciplinary remedial action being investigated by the board."

provide the Board with certain medical records.<sup>30</sup> Exhibit 8 page 3; Exhibit 10, page 3; Exhibit 11, page 2. The testimony evidenced that the Respondent has not responded to any of these.<sup>31</sup>

The Respondent's failure to alert staff and/or patients of Riverfront's abrupt closure left patients in a lurch, scrambling for continuing medical coverage. The Respondent's continuing failure to respond to patients' requests for medical records has created problems for scores of her former patients. At the time of Riverfront's closure, the Board's office was receiving several telephone calls each day from patients who were seeking their medical records and were not receiving any response from the Respondent. There has been a continuous stream of patients who have been calling for this reason alone. As of the date of the hearing, about 15 weeks after Riverfront's closure, the Board's office was still receiving an average of three to four (3-4) telephone calls each week from former patients of the Respondent complaining that the Respondent has not provided them with their medical records. The Board's Investigator testified: "It's been over 30 days and they just still have not received them or the receiving provider has not received them." Transcript, page 14. The Board's office has been referring these patients to the Respondent's prior attorney. However, it appears that neither that attorney, nor the Respondent, have been responding to requests for patients' medical records. Exhibits 4, 8, 10, and 11.

#### **Rulings of Law:**

##### **Applicable Laws:**

- RSA 329:17, VI (d):

VI. The board, after hearing, may take disciplinary action against any person licensed by it upon finding that the person: ...

(d) Has engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent in practicing medicine or in performing activities ancillary to the practice of medicine or any particular aspect or specialty thereof, or has intentionally injured a patient while practicing medicine or performing such ancillary activities.

- Med 501.01 Obligation to Obey.

(a) The ethical standards set forth in this part shall bind all licensees, and violation of any such standard shall constitute unprofessional conduct within the meaning of RSA 329:17, VI(d).

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<sup>30</sup> RSA 329:18, VII: "The board may also require the licensee or applicant to provide the board with complete copies of records concerning any patient whose treatment may be material to allegations of possible professional misconduct or grounds for non-disciplinary remedial action being investigated by the board."

<sup>31</sup> RSA 329:18, VII: "Licensees and applicants shall respond to either type of request within 15 days from the date of the request, or within such greater time period as the board may specify."

- Med 501.02 Standards of Conduct.

**(c) A licensee shall cooperate with investigations and requests for information from the board** and from other licensing or credentialing organizations.

...  
 (f) A licensee shall promptly honor requests made by a patient or an authorized agent of a patient, for complete copies of the patient's medical record in accordance with the following standards:

- (1) A licensee shall be ultimately responsible for transferring copies of medical records regardless of whether the licensee has delegated this task to another person or organization;
- (2) Upon the patient's request, the licensee shall provide copies of the medical records, either a specified portion or the entire contents depending on the patient's request, regardless of whether the licensee created the records or the records were provided to the licensee by another health care provider;
- (3) The licensee may charge the actual cost of duplication for X-rays or other color photographs;
- (4) Upon receipt of a written release, the requested transfer of medical records shall:**
  - a. Not be delayed, including for non-payment of services or non-payment of copying costs and of costs for transmitting of medical records; and
  - b. Be accomplished in any case within 30 days from the receipt of the signed release, unless the nature of the medical treatment requires an immediate response from the licensee;**

...  
 (h) A licensee shall adhere to the most current edition of the Code of Medical Ethics - Current Opinions With Annotations (2010-2011 Edition) as adopted by the American Medical Association. ... Licensees shall adhere to the ethical rules in effect at the time of the conduct at issue.

- AMA Code of Ethics Opinion 5.05

The information disclosed to a physician by a patient should be held in confidence. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the physician will respect the confidential nature of the communication. The physician should not reveal confidential information without the express consent of the patient, subject to certain exceptions which are ethically justified because of overriding considerations. ...

- AMA Code of Ethics Opinion 5.059

The In the context of health care, emphasis had been given to confidentiality, which is defined as information told in confidence or imparted in secret. However, physicians also should be mindful of patient privacy, which encompasses information that is concealed from others outside of the patient-physician relationship.

Physicians must seek to protect patient privacy in all of its forms, including (1) physical, which focuses on individuals and their personal spaces, (2) informational, which involves specific personal data, (3) decisional, which focuses on personal choices, and (4) associational, which refers to family or other intimate relations. Such respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship.

Privacy is not absolute, and must be balanced with the need for the efficient provision of medical care and the availability of resources. Physicians should be aware of and respect the special concerns of their patients regarding privacy. Patients should be informed of any significant infringement on their privacy of which they may otherwise be unaware.

Rulings:

The Board makes the following findings by a preponderance of the evidence:

- A. The Respondent engaged in professional misconduct by failing to alert patients of the possibility of the practice's closure, in violation of RSA 329:17, VI (d).
- B. The Respondent engaged in professional misconduct by failing to alert staff of the possibility of the practice's closure, in violation of RSA 329:17, VI (d).
- C. Around February 2011 through March 2011:
  - a. The Respondent failed to provide patient records within 30 days pursuant to a request from LD in violation of RSA 329:17, VI(d).
  - b. The Respondent failed to provide patient records within 30 days pursuant to a request from LD in violation of Med 501.02(f)(4)(b).
- D. Around February 2011 through March 2011:
  - a. The Respondent failed to provide patient records within 30 days pursuant to a request from JM in violation of RSA 329:17, VI(d).
  - b. The Respondent failed to provide patient records within 30 days pursuant to a request from JM in violation of Med 501.02(f)(4)(b).
- E. Around February 2011 through March 2011:
  - a. The Respondent failed to provide patient records within 30 days pursuant to a request from JM for HM in violation of RSA 329:17, VI(d).
  - b. The Respondent failed to provide patient records within 30 days pursuant to a request from JM for HM in violation of Med 501.02(f)(4)(b).
- F. None.
- G. Around February 2011 through March 2011:
  - a. The Respondent failed to provide patient records within 30 days pursuant to a request from CH in violation of RSA 329:17, VI(d).
  - b. The Respondent failed to provide patient records within 30 days pursuant to a request from CH in violation of Med 501.02(f)(4)(b).
- H. Around February 16, 2011:
  - a. The Respondent committed professional misconduct by failing to comply with a Board subpoena, in violation of RSA 329:17, VI(d).
  - b. The Respondent committed professional misconduct by failing to comply with a Board subpoena, in violation of Med 501.02(c).
- I. Around February 23, 2011 through March 18, 2011:
  - a. The Respondent committed professional misconduct when she failed to respond to various inquiries made pursuant to a Board investigation in violation of RSA 329:17, VI(d).
  - b. The Respondent committed professional misconduct when she failed to respond to various inquiries made pursuant to a Board investigation in violation of Med 501.02(c).
- J. On or between February 18, 2011 and February 23, 2011:
  - a. The Respondent committed professional misconduct when she failed to safeguard PL's confidential patient information, in violation of RSA 329:17, VI (d).

- b. The Respondent committed professional misconduct when she failed to safeguard PL's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard PL's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard PL's confidential patient information, in violation of AMA Code 5.059.
- K. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard AJ's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard AJ's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard AJ's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard AJ's confidential patient information, in violation of AMA Code 5.059.
- L. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard JK's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard JK's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard JK's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard JK's confidential patient information, in violation of AMA Code 5.059.
- M. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard LG's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard LG's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard LG's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard LG's confidential patient information, in violation of AMA Code 5.059.
- N. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard RJ's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard RJ's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard RJ's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard RJ's confidential patient information, in violation of AMA Code 5.059.
- O. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard JA's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard JA's confidential patient information, in violation of Med 501.02 (h).

- c. The Respondent committed professional misconduct when she failed to safeguard JA's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard JA's confidential patient information, in violation of AMA Code 5.059.
- P. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard CBF's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard CBF's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard CBF's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard CBF's confidential patient information, in violation of AMA Code 5.059.
- Q. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard JP's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard JP's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard JP's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard JP's confidential patient information, in violation of AMA Code 5.059.
- R. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard TV's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard TV's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard TV's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard TV's confidential patient information, in violation of AMA Code 5.059.
- S. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard DP's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard DP's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard DP's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard DP's confidential patient information, in violation of AMA Code 5.059.
- T. None.
- U. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard JW's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard JW's confidential patient information, in violation of Med 501.02 (h).



- d. The Respondent committed professional misconduct when she failed to safeguard KB's confidential patient information, in violation of AMA Code 5.059.
- AA. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard JN's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard JN's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard JN's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard JN's confidential patient information, in violation of AMA Code 5.059.
- BB. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard SB's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard SB's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard SB's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard SB's confidential patient information, in violation of AMA Code 5.059.
- CC. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard GC's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard GC's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard GC's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard GC's confidential patient information, in violation of AMA Code 5.059.
- DD. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard SR's confidential patient information, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard SR's confidential patient information, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard SR's confidential patient information, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard SR's confidential patient information, in violation of AMA Code 5.059.
- EE. On or between February 18, 2011 and February 23, 2011:
- a. The Respondent committed professional misconduct when she failed to safeguard patient information on patient sign in sheets, in violation of RSA 329:17, VI (d).
  - b. The Respondent committed professional misconduct when she failed to safeguard patient information on patient sign in sheets, in violation of Med 501.02 (h).
  - c. The Respondent committed professional misconduct when she failed to safeguard patient information on patient sign in sheets, in violation of AMA Code 5.05.
  - d. The Respondent committed professional misconduct when she failed to safeguard patient information on patient sign in sheets, in violation of AMA Code 5.059.

### Outstanding Complaints:

Disturbingly, the manner in which the Respondent abruptly closed the Riverfront practice has disrupted the lives of scores of patients. These patients now do not have access to their medical records. These patients' new medical providers do not have access to their patients' medical records. The new practitioners' ability to care for, diagnose, and treat patients is thwarted when this doctor does not have a patient's medical history as contained in the patient's medical record. The physician's ability to maintain the continuity of patient care, the ability to prescribe medications without changing the consistency or dosage (especially for the vulnerable population of pain controlled patients that the Respondent had primarily treated), is hampered without the ability to review these records. Furthermore, the individual patient's ability to seek medical care with another provider is greatly diminished by the reluctance of other practices to take on new patients that do not have their medical history available. Most critical is those patients who are currently in the throes of needing urgent care (surgery and the like) and their providers are unable to access their medical records (e.g. to know adverse reactions to medications, to know details of prior medical procedures, and to know other contraindications based on medical history).

The New Hampshire Legislature has recognized the importance of patients' fundamental rights to their medical records. In RSA 332-I:1, I, the law states: "All medical information contained in the medical records in the possession of any health care provider shall be deemed the property of the patient." In this statute, the Legislature also mandated that patients be able to obtain their medical records to ensure the continuity of care of the citizens of New Hampshire. "The patient **shall be entitled** to a copy of such records upon request." (emphasis added). The Respondent's blatant disregard for her former patients' rights violates this law.

The Respondent's flagrant disregard for the Board's subpoenas of these records also violates the law.

Licenseses ... have a statutory duty to provide detailed, good faith written response[s] to allegations of possible professional misconduct being investigated by the board. If requested, they must also provide "complete copies of records concerning any patient whose treatment may be material to allegations of possible professional misconduct being investigated by the board." Id. A licensee who does not comply with this duty to assist the

board in its investigation may be sanctioned. Likewise, under the New Hampshire Code of Administrative Rules, a person to whom a subpoena is issued ... has a duty to comply with the subpoena. A person who fails to comply with this rule may have an adverse order issued against him, and the board may employ the statutory remedies available under RSA 329:17.

Appeal of Rowan, 142 N.H. 67, 72-72 (1997) (quotation marks and citations omitted).

Hearing Counsel has asked that the Board fine the Respondent one thousand dollars (\$1,000) for the four patients for whom there are written complaints regarding their failure to receive their records despite multiple requests. Exhibit 8 (LD); Exhibit 10 (JM & HM); Exhibit 11 (ATH). Hearing Counsel has also asked that the Board issue an order that there is an automatic one thousand dollar (\$1,000) fine whenever the Respondent fails to provide a patient with records within 30 days of a written request. While the former is within the clear purview of the Board's jurisdiction (RSA 329:17, VII), the latter is less apparent. On the one hand, if the Board were to issue such 'automatic' fines based upon the patient-complaint's assertion, there might be a due process (notice and hearing) violation. On the other hand, if the Board were to notice and hear each and every one of these scores of cases, it would strain the efficacy of this limited-resource agency comprised of volunteer practitioners and lay-persons who meet monthly to effectuate the purposes of RSA chapter 329; more importantly, the Board queries the de facto consequences of the multitude of such hearings where the Respondent has shown blatant disregard for the Board's authority. Indicia of this disregard are: (1) her failure to comply with her 9/8/10 Settlement Agreement as it relates to the administrative fine; (2) her practice of medicine while under suspension from this Board; and (3) her failure to appear at the June 1, 2011 hearing.

"The primary purposes of RSA chapter 329 are to assure a high quality of medical care and to protect the public from persons unfit to practice medicine." Appeal of Plantier, 126 N.H. 500, 508 (1985); Appeal of Rowan, 142 N.H. 67, 74 (1997). "These goals require that the board possess expansive authority regarding the licensure of medical practitioners and broad authority to discipline members of the profession." Rowan, at 67. "To that end, the board is given the authority to undertake disciplinary action to protect the public interest." Plantier, at 508.

In light of the Board's public protection mission, the Board rules as follows:

1. The Respondent's compliance with Board's subpoena for LD's medical records were due "on or before the 23<sup>rd</sup> day of March 2011." The Respondent's response to LD's complaint was due on the same day. From that date to the date of the hearing were seventy (70) days. The Board has the authority to assess, in the case of continuing offenses, an administrative fine of \$300 for each day that the violation<sup>32</sup> continues. Seventy days multiplied by three hundred dollars (70x300) equals twenty one thousand dollars (\$21,000).
2. The Respondent's compliance with Board's subpoena for JM's medical records were due "on or before the 10<sup>th</sup> day of April 2011." The Respondent's response to JM's complaint was due on the same day. From that date to the date of the hearing were fifty-two (52) days. The Board has the authority to assess, in the case of continuing offenses, an administrative fine of \$300 for each day that the violation<sup>33</sup> continues. Fifty-two days multiplied by three hundred dollars (52x300) equals fifteen thousand six hundred dollars (\$15,600).
3. The Respondent's compliance with Board's subpoena for HM's medical records were due "on or before the 10<sup>th</sup> day of April 2011." From that date to the date of the hearing were fifty-two (52) days. The Board has the authority to assess, in the case of continuing offenses, an administrative fine of \$300 for each day that the violation<sup>34</sup> continues. Fifty-two days multiplied by three hundred dollars (52x300) equals fifteen thousand six hundred dollars (\$15,600).
4. The Respondent's compliance with Board's subpoena for ATH's medical records were due "on or before the 13<sup>th</sup> day of April 2011." The Respondent's response to CH's complaint was due on the same day. From that date to the date of the hearing were forty-nine (49) days. The Board has the authority to assess, in the case of continuing offenses, an administrative fine of \$300 for each day that the violation<sup>35</sup> continues. Forty-nine days multiplied by three hundred dollars (49x300) equals fourteen thousand seven hundred dollars (\$14,700).

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<sup>32</sup> NOH, paragraph 6C.

<sup>33</sup> NOH, paragraph 6D.

<sup>34</sup> NOH, paragraph 6E.

<sup>35</sup> NOH, paragraph 6G.

5. A written accounting by the Respondent is required to ensure that there is not a public safety crisis where multitudes of patients are unable to access their medical records and/or receive copies thereof. In light of the Respondent's assertions in the email to Hearing Counsel on February 22, the Board requires detailed accountings **starting within 7 days of the effective date of this Order.**

**Disciplinary Action:**

After making its findings of fact and rulings of law, the Board deliberated on the appropriate disciplinary action. RSA 329:17, VII ("The board, upon making an affirmative finding under paragraph VI, may take disciplinary action in any one or more of the following ways:...").

IT IS ORDERED that (pursuant to findings A and B) the Respondent is REPRIMANDED.

IT IS FURTHER ORDERED that (pursuant to findings J through EE) the Respondent is assessed an administrative fine in the amount of one thousand dollars per offense. As there are twenty-one (21) found offenses, the administrative fine is in the amount of twenty-one thousand dollars (\$21,000.00).

IT IS FURTHER ORDERED that (pursuant to findings C, D, E and G) that the Respondent is assessed an administrative fine in the amount of sixty-six thousand, nine hundred dollars (\$66,900.00).

IT IS FURTHER ORDERED that the Respondent pay this entire sum of eighty-seven thousand nine hundred dollars (\$87,900.00) within nine months (9 months) of the effective date of this Settlement Agreement. The entirety of the payment is due on or before April 4, 2012. The payment shall be made in the form of a money order or bank check made payable to "Treasurer, State of New Hampshire" and delivered to the Board's office at 2 Industrial Park Drive, Suite 8, Concord, NH 03301.

IT IS FURTHER ORDERED that the Respondent provide the written detailed accountings as follows:

- a. Within 7 days of the effective date of this Order,<sup>36</sup> the Respondent shall provide a detailed written accounting of the measures she has taken to ascertain which

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<sup>36</sup> The effective date of this order is July 11, 2011; thus, on or before Monday, July 18, 2011. This deadline is immutable.

patients have made requests<sup>37</sup> (on behalf of themselves or others) for their medical records. These requests may have been made orally, by fax, by phone, or in writing. These requests may have been made to Riverfront, to the Respondent, to the Board, to Attorney Bartholomew, or to Attorney Maggiotto. **The Respondent shall provide copies of medical records pursuant to these requests and in accordance with the Board's administrative rules, particularly Med 501.02 (f).** Furthermore, the Respondent's detailed written accounting will also include when and where each of these medical records were sent.

- b. Within 7 days of the effective date of this Order,<sup>38</sup> the Respondent shall provide a detailed written accounting of the measures she has taken to ascertain which patients have been seen at Riverfront (by any provider) in the three (3) years prior to its closing. The Respondent shall create a list of patients seen between February 22, 2008 and February 22, 2011.
- c. Also within 7 days of the effective date of this Order,<sup>39</sup> the Respondent shall provide a detailed written accounting of the measures she has taken to alert the patients on the list in the previous paragraph: (1) that copies of their medical records are available; (2) how these patients could obtain copies of their medical records from the Respondent; and (3) of this Final Decision and Order.
- d. Also within 7 days of the effective date of this Order,<sup>40</sup> the Respondent shall provide a written plan detailing the measures she has taken to ensure all former patients (of

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<sup>37</sup> Any and all medical record requests made between January 1, 2011 through the date of this Order, including the requests discussed in this Order.

<sup>38</sup> On or before Monday, July 18, 2011. As to this paragraph - to the extent the Respondent cannot meet this deadline, she may petition the Board, in writing, on or before this date, explaining (1) why she is not able to meet this deadline; (2) what measures she has taken in furtherance of complying with this sanction; and (3) when she will be able to comply with this sanction. Nothing stated herein shall be construed to change this deadline unless and until done so through a written Board order.

<sup>39</sup> On or before Monday, July 18, 2011. As to this paragraph - to the extent the Respondent cannot meet this deadline, she may petition the Board, in writing, on or before this date, explaining (1) why she is not able to meet this deadline; (2) what measures she has taken in furtherance of complying with this sanction; and (3) when she will be able to comply with this sanction. Nothing stated herein shall be construed to change this deadline unless and until done so through a written Board order.

<sup>40</sup> On or before Monday, July 18, 2011. As to this paragraph - to the extent the Respondent cannot meet this deadline, she may petition the Board, in writing, on or before this date, explaining (1) why she is not able to meet this

the Respondent or Riverfront) are able to receive their records upon request in the future (to wit, after the effective date of this Order).

- e. Within 60 days of the effective date of this Order,<sup>41</sup> the Respondent shall provide a detailed written accounting of the measures she has taken to comply with Med 501.02 (f) in providing copies of the medical record requests made pursuant to the previous paragraph. The Respondent's detailed written accounting shall include an accounting of the incoming requests, and when and where these medical records were sent.
- f. All written accountings shall be sent to the attention of Dori Tothill, Board Investigator, at 2 Industrial Park Drive, Suite 8, in Concord New Hampshire.
- g. The Respondent's failure to provide any one of these detailed accountings as required or in a timely fashion shall constitute unprofessional conduct pursuant to RSA 329:17, VI and shall allow the Board to assess administrative fines for continuing violations in the amount of \$300.00(three hundred dollars) for each day that the violation continues pursuant to RSA 329:17, VII.
- h. The Respondent's failure to provide medical records as required or in a timely fashion shall constitute unprofessional conduct pursuant to RSA 329:17, VI and shall allow the Board to assess administrative fines for continuing violations in the amount of \$300.00(three hundred dollars) for each day that the violation continues pursuant to RSA 329:17, VII.

IT IS FURTHER ORDERED that the Board will take any necessary administrative, civil, injunctive, equitable and/or criminal action to enforce this Final Decision and Order.

IT IS FURTHER ORDERED that the Board will hold a hearing in this matter to review whether the Respondent has properly provided the written detailed accountings. This hearing will be scheduled upon the request of Hearing Counsel or the Respondent. Failure on the Respondent's part to

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deadline; (2) what measures she has taken in furtherance of complying with this sanction; and (3) when she will be able to comply with this sanction. Nothing stated herein shall be construed to change this deadline unless and until done so through a written Board order.

<sup>41</sup> On or before September 10, 2011.

properly provide these accountings may result in the Board's assessing a cumulative fine for any or all of the accountings from the date on which each accounting was due; and assessing a cumulative fine for any and all of the medical records requests due. Full compliance on the Respondent's part to properly provide patients with medical records and the Board with the enumerated accountings may result in the Board's suspension or waiver of up to seventy-seven thousand nine hundred dollars (\$77, 900) of the administrative fine assessed for violations (pursuant to findings C, D, E and G & JJ through EE).

IT IS FURTHER ORDERED that this Final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document.

IT IS FURTHER ORDERED that this Final Decision and Order shall take effect as an Order of the Board on the date an authorized representative of the Board signs it.

Date: July 11, 2011

\*BY ORDER OF THE NEW HAMPSHIRE  
BOARD OF MEDICINE

Penny Taylor  
(Signature)

PENNY TAYLOR  
(Print or Type Name)

Authorized Representative of the  
New Hampshire Board of Medicine

\*\ Amy Feitelson, M.D., Board member, recused.