APPENDIX TABLE OF CONTENTS

APPENDIX A
OPINION OF THE MASSACHUSETTS SUPREME JUDICIAL COURT (OCTOBER 27, 2022)

MASSACHUSETTS SUPREME JUDICIAL COURT

SHELDON SCHWARTZ

v.

BOARD OF REGISTRATION IN MEDICINE

No. SJC-13292

The petitioner, Sheldon Schwartz, appeals from a judgment of a single justice of this court affirming a final decision and order of the Board of Registration in Medicine (board) suspending indefinitely his license to practice medicine. We affirm.

Procedural background.

In December 2015, the board issued a statement of allegations and order to show cause why the board should not discipline Schwartz. The board alleged that Schwartz committed misconduct in the practice of medicine; that he lacked good moral character and engaged in conduct that undermines public confidence in the integrity of the medical profession; and that, by his actions, he violated Board of Registration in Medicine Policy No. 01-01 (disruptive physician behavior policy). The board referred the matter to the Division of Administrative Law Appeals (DALA),

and an administrative magistrate held a hearing over eight days in 2016. The magistrate subsequently issued a recommended decision finding that Schwartz's disruptive behavior on two separate occasions amounted to misconduct and demonstrated that he engaged in conduct that undermines the public confidence in the integrity of the medical profession. On this basis, the magistrate concluded that Schwartz is subject to discipline by the board.[1]

The board adopted the findings and conclusions of the magistrate, over various objections from Schwartz, and, after further briefing by the parties on the issue of sanctions, concluded that Schwartz's actions warranted an indefinite suspension of his license to practice medicine. In issuing the sanction, the board also provided that any petition to stay the suspension would be conditioned on Schwartz's completion of (1) a new evaluation by Physician Health Services and following any recommendations resulting from the evaluation; (2) a board-approved course in anger management; and (3) a board-approved course in conflict management.

Schwartz thereafter filed a petition for judicial review in the county court pursuant to G. L. c. 112, § 64, and a single justice of this court affirmed the board's decision. Schwartz appeals.

Relevant factual background.

The magistrate's recommendation that Schwartz be subject to discipline stems, principally, from incidents that occurred on two different dates, while

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[1] The magistrate issued the recommended decision in December 2020, more than four years after the 2016 hearing.

Schwartz was employed as an internist at Arbour–HRI Hospital (Arbour), a psychiatric hospital in Brookline. On February 28, 2013, at the end of a daily meeting, at which Arbour's senior management met to review and discuss admissions, discharges, clinical issues, and other matters, Schwartz, who did not regularly attend the daily meetings, knocked and entered the meeting room. He was specifically concerned about access to certain patient records while the hospital's computerized medical records system was offline for maintenance. He was upset, agitated, and loud. A nurse executive, Michelle McIntosh, led him away from the meeting room, which was located in the executive suite at the hospital, to take him to meet with Arbour's chief financial officer, James Rollins. Rollins had not been at the meeting. While McIntosh and Schwartz were looking for Rollins, Schwartz called McIntosh a "bitch" while they were in a hallway outside the executive suite. After McIntosh and Schwartz found Rollins, McIntosh told him what had happened at the meeting. Cheryl Grau, a social worker and the clinical services director at Arbour, was also Page 1027 present for part of the meeting with Rollins, but she left after Schwartz told her that she was "corporate now" and that he could "buy and sell [her] a billion times."

On the other date relevant to the magistrate's decision, May 30, 2013, two different incidents occurred involving Schwartz and various coworkers. While Schwartz was finishing assessment notes on a patient in a treatment room, which also served as his office, a nurse asked him if Allison Ippolito, a social worker, and Jen Moran, a mental health worker, could use the room to examine a new patient. Schwartz responded

"no" without explanation. Ippolito and Moran examined the patient in a bathroom instead.[2] When they returned with the patient to the treatment room, Schwartz and Dr. Krishnaswamy Gajaraj were outside the room arguing loudly, apparently about the necessity of medication for a particular patient. When Ippolito and Moran told the doctors that there was a patient in the treatment room who could hear them, Schwartz responded, "I don't care."

On the following day, Schwartz met with Patrick Moallemian, then Arbour's chief executive officer, to discuss the previous day's incidents. Schwartz admitted that he had been disruptive, and he apologized to at least some of the staff who had been present at the time. Moallemian gave Schwartz a letter of suspension, which had been prepared in advance, summarily suspending Schwartz based on his behavior. On the day that Schwartz's suspension ended, June 19, 2013, Schwartz resigned from Arbour.

In her recommended decision, the magistrate also noted the following, among other things: that Schwartz was good with patients; that some medical staff agreed with Schwartz's view about patient care at Arbour and appreciated his efforts to improve patient safety; that Schwartz and Moallemian had a tense relationship; that Schwartz had a positive relationship with, and was respected by, two of Arbour's former medical directors; and that following an incident in September 2013, Moallemian was dismissed from Arbour and that McIntosh was asked to resign.

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[2] Although this was not the first time a patient had been examined in the bathroom rather than in a treatment room, it was technically against hospital policy.

Additionally, of note, this was not Schwartz's first violation of the disruptive physician behavior policy. In 2012, he entered into a consent order with the board in which he admitted to violating the policy and pursuant to which the board issued a reprimand against him.

Discussion.

"Under G. L. c. 112, § 64, a person whose license to practice medicine has been [suspended, revoked, or canceled] may petition the court to 'enter a decree revising or reversing the decision . . . in accordance with the standards for review provided' in G. L. c. 30A, § 14 (7)." *Clark v. Board of Registration of Social Workers*, 464 Mass. 1008, 1009 (2013), quoting *Weinberg v. Board of Registration in Med.*, 443 Mass. 679, 685 (2005). "The court may modify or set aside the board's final decision only if the petitioner demonstrates that the decision was legally erroneous, procedurally defective, unsupported by substantial evidence, arbitrary or capricious, or contained one or more of three other enumerated defects not at issue here." *Weinberg, supra*, citing *Fisch v. Board of Registration in Med.*, 437 Mass. 128, 131 (2002). "This court reviews the Massachusetts board's decision directly, even though the appeal is from a decision of a single justice" (quotation and citation omitted). *Knight v. Board of Registration in Med.*, 487 Mass. 1019, 1022 (2021), and cases cited.

Schwartz's arguments can be loosely grouped into four categories: (1) that the board did not have the authority to issue a statement of allegations against him, and that DALA, in turn, did not have jurisdiction to consider those allegations; (2) that the magis-

trate improperly considered certain evidence at the hearing, and that the evidence was insufficient to support her recommended decision; (3) that he is entitled to a jury trial on the issue of the indefinite suspension of his license to practice medicine; and (4) that the board's decision to indefinitely suspend was legally erroneous or arbitrary and capricious. We address each of these in turn.

1. Authority and jurisdiction of the board and DALA.

In its statement of allegations against him, the board alleged that Schwartz had violated the board's disruptive physician behavior policy, the relevant portions of which are set forth in the margin.[3] In

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[3] Board of Registration in Medicine Policy No. 01-01 provides in relevant part:

> "The American Medical Association (AMA) has defined disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. The recent Institute of Medicine study concluded that health care systems must promote teamwork, the free exchange of ideas, and a collaborative approach to problem solving if medical errors are to be reduced. Disruptive behavior by a physician has a deleterious effect upon the health care system and increases the risk of patient harm.
>
> "The Board strongly urges physicians to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. Behavior by a physician that is disruptive, and compromises the quality of medical care or patient safety, could be grounds for Board discipline. . . .
>
> "Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family

Schwartz's view, the board did not have the authority to issue an allegation against him because the board did not establish both that his behavior was disruptive and that the behavior had an impact on patient care, which Schwartz argues is required by the policy. The policy, however, does not provide the sole basis upon which the board sought to discipline him. As the board noted in its statement of allegations, it may, pursuant to its regulations, discipline a physician upon proof that the physician has committed "[m]isconduct in the practice of medicine." 243 Code Mass. Regs. § 1.03(5)(a)(18) (2012). In other words, Schwartz need not necessarily have violated the disruptive physician behavior policy to be subject to discipline.

That said, we do not agree with Schwartz that his behavior did not have an impact on patient care.[4] When a patient overhears doctors arguing with each other, and hears a doctor state that he does not care that patients can hear the argument, there is an impact on patient care. Furthermore, even if much of Schwartz's disruptive behavior occurred outside of patients' hearing, that behavior clearly affected Schwartz's relationship with his colleagues, and it is not hard to imagine that this, in turn, can have an impact on patient care. There is, in short, no basis for Schwartz's argument that the board had no authority to issue the statement of allegations against him. Schwartz's argument that DALA lacked authority, or jurisdiction, is equally unavailing, stemming, as it

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members are now recognized as detrimental to patient care." (Footnotes omitted.)

[4] There is no question that Schwartz's behavior was disruptive, and he himself does not genuinely argue otherwise.

does, from his argument regarding the board's purported lack of authority.

2. Magistrate's consideration of the evidence.

Schwartz next raises a number of arguments related to the evidence presented at the DALA hearing, ranging from the magistrate's consideration of the evidence to the sufficiency of that evidence. He argues, for example, that the magistrate ignored certain testimony; that she improperly relied on unsworn testimony; and that she improperly relied on certain character evidence. To the contrary, the magistrate's recommended decision, which was adopted by the board, indicates careful and thoughtful consideration of the evidence. She specifically indicated which witnesses she found credible and reliable, and how those determinations affected her consideration of conflicting testimony. She also noted that she gave little or no weight to written statements from individuals who did not testify.

As to the latter point, Schwartz argues that the magistrate did, in fact, rely on a statement from an individual who did not testify, Ippolito. Furthermore, according to Schwartz, Ippolito's statement was the only evidence that a patient heard Schwartz and Gajaraj arguing outside a treatment room. That is incorrect. Among the exhibits admitted in evidence at the DALA hearing was an e-mail message from Schwartz to Moallemian, dated May 31, 2013, in which Schwartz admitted that he had been disruptive, that he was sorry that a patient had become upset by their behavior, and that he had apologized to the staff.

Schwartz also argues that individual members of the board defied State law or ignored certain unethical conduct on the part of the attorney representing the board in the proceedings against Schwartz. The arguments, at least some of which are being raised here for the first time, do not amount to adequate appellate argument. *See* Mass. R. A. P. 16 (a) (9), as appearing in 481 Mass. 1628 (2019). Schwartz's argument that he was prejudiced by the approximately four-year delay between the DALA hearing and the magistrate's recommended decision suffers from the same problem-that is, it does not amount to adequate appellate argument. We note as well that, during that period, Schwartz had not yet been subject to any discipline and his license to practice medicine, therefore, had not yet been suspended.

3. Jury trial.

We next consider Schwartz's argument that the indefinite suspension of his license without a jury trial "offends" the Massachusetts Declaration of Rights. There is no merit to this argument. To the extent that Schwartz suggests that his license to practice medicine is a property right, he is correct, but that alone does not entitle him to a jury trial. *See Matter of Gargano*, 460 Mass. 1022, 1025 (2011), *cert. denied*, 566 U.S. 921 (2012) (no right to jury trial in matter involving suspension of license to practice law), and cases cited.

4. Sanction.

Finally, we turn to the issue of the sanction–the indefinite suspension of Schwartz's license to practice medicine. As noted above, although we review the

board's decision directly, we will only modify or set aside the decision if Schwartz demonstrates that the decision was "legally erroneous, procedurally defective, unsupported by substantial evidence, arbitrary or capricious." *Weinberg*, 443 Mass. at 685. Schwartz does not specifically contest the sanction. His dissatisfaction, at least so far as set forth in this court, lies largely with the DALA and board proceedings, but he says little about the sanction itself. We have nevertheless reviewed the record and agree with the single justice that it supports the board's conclusions that Schwartz engaged in misconduct in the practice of medicine and violated the board's disruptive physician behavior policy and 243 Code Mass. Regs. § 1.03(5)(a)(18).

In reaching its decision, the board noted that it has imposed sanctions ranging from admonishment to license suspension for disruptive conduct and that a reprimand was the sanction most often imposed. Indeed, that is the sanction that the board imposed the first time that it found that Schwartz violated the disruptive physician behavior policy, in 2012. As the board also noted, in imposing sanctions it considers, among other things, patterns in a physician's misconduct. Where the board had already previously reprimanded Schwartz, a harsher sanction, in the circumstances, is neither legally erroneous nor arbitrary and capricious.

Conclusion.

The board's decision, which adopted the magistrate's recommended decision, was supported by the evidence, and Schwartz has not demonstrated that the decision was legally erroneous, procedurally

defective, or arbitrary or capricious. We therefore affirm the judgment of the single justice.

So ordered.

The case was submitted on briefs.

Sheldon Schwartz, pro se.

Timothy R. McGuire, Assistant Attorney General, for the respondent.

APPENDIX B
MEMORANDUM OF DECISION AND JUDGMENT OF THE COMMONWEALTH COURT OF MASSACHUSETTS (MAY 11, 2022)

COMMONWEALTH OF MASSACHUSETTS

SHELDON SCHWARTZ, M.D.

v.

BOARD OF REGISTRATION IN MEDICINE

Supreme Judicial Court for Suffolk County
No. SJ-2021-0231

Board of Registration in Medicine
No. 2015-037 (RM-15-648)

Before: Dalila ARGAEZ WENDLANDT,
Associate Justice.

MEMORANDUM OF DECISION AND JUDGMENT

This matter came before the Court, Wendlandt, J, on a petition for judicial review, pursuant to G. L. c. 112, § 64, in which petitioner, Sheldon Schwartz, M.D., seeks review from a final decision and order of the Board of Registration in Medicine (the Board) dated May 20, 2021, which indefinitely suspended his license to practice medicine.

The administrative record was filed in this Court on December 10, 2021. The brief of the petitioner was docketed on February 28, 2022. The memorandum of the Board was docketed on April 28, 2022.

1. Background.

Petitioner was an internist at Arbour-HRI Hospital between 2005 and 2013. After an evidentiary hearing that included fifty-nine exhibits and dozens of witnesses' testimony, the Board found that the petitioner engaged in "disruptive behavior" in 2013. The petitioner had previously been reprimanded by the Board for violating the Disruptive Behavior policy in 2012.

In February of 2013, the hospital's senior management was holding a daily "flash meeting" to discuss admissions, discharges, clinical issues, and other matters that occurred during the previous twenty-four hours. That day, the hospital's computerized medical records system was offline. The petitioner, who did not usually attend these meetings, came into the meeting as it was ending; he wanted to discuss the lack of access to patient records and an influx of new patients. He was upset, agitated, and loud. A registered nurse led the petitioner away from the meeting so that the petitioner could meet with hospital leadership to discuss the technology issues; while they walked down the hall, the petitioner called the nurse a "bitch." He later apologized to patients attending a nearby group therapy session. In the meeting that occurred with the hospital leadership soon after, the petitioner told a different hospital administrator that she was "corporate now" and that he could "buy

and sell [her] a million times." He was upset and agitated for much of this meeting.

In May of 2013, the petitioner was asked to leave an examination room that was currently serving as his office so that mental health workers could perform a routine safety search of a new patient required before a patient may see a doctor. The patient was with them. The petitioner curtly said "No," and the staff conducted the search in a different room that was technically in violation of hospital policy but had been used for this purpose before. When the staff returned from conducting the patient search, they saw the hospital's Medical Director and the petitioner arguing loudly about medications for a patient at the nurses' station, where the patient could hear them.[1] When told that the patient could hear their argument, the petitioner responded, "I don't care." The patient was upset at overhearing the argument. As a result of these incidents, the petitioner was suspended from the hospital by the Chief Executive Officer, with whom the petitioner generally did not get along. And, as discussed supra, the Board sanctioned the petitioner by indefinitely suspending him.

2. Standard of review.

"'[A] person whose certificate, registration, license or authority has been suspended, revoked or cancelled,' may obtain review by the Supreme Judicial Court of the board's decision in accordance with the standards provided in G. L. c. 30A, § 14." *Friedman v. Board of Registration of Medicine*, 414 Mass. 663, 664 (1993),

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[1] The petitioner and the Medical Director had a long-standing acrimonious relationship.

quoting G. L. c. 112, § 64. G. L. c. 30A, § 14, in turn, authorizes this court to reverse, remand, or modify a decision of the Board if we determine "that the substantial rights of any party may have been prejudiced because" the Board's decision is, inter alia, in excess of its statutory authority or jurisdiction, based upon an error of law, unsupported by substantial evidence, or arbitrary or capricious. G. L. c. 30A, § 14(7). In our review, we give "due weight to the experience, technical competence, and specialized knowledge of the agency, as well as to the discretionary authority conferred upon it." *Id. See Fisch v. Board of Registration in Medicine*, 437 Mass. 128, 131 (2002).

"[I]n reviewing the penalty imposed by an administrative body . . . neither a trial court nor an appellate court is free to substitute its own discretion as to the matter; nor can the reviewing court interfere with the imposition of a penalty by an administrative tribunal because in the court's own evaluation of the circumstances the penalty appears to be too harsh.'" *Levy v. Board of Registration in Medicine*, 378 Mass. 519, 529 (1979), quoting *Shakin v. Board of Medical Examiners*, 254 Cal. App. 2d 102, 112-113 (1967). Rather, "a request for [this court] to interfere with a board's exercise of its sound discretion is only appropriate in the most extraordinary of circumstances." *Id.* at 528-529. We thus "review the sanction imposed for an abuse of discretion," *Birudavol v. Board of Registration of Medicine*, 448 Mass. 1031, 1033 (2007), looking to whether "the sanction imposed was . . . disproportionate to sanctions imposed in other cases" with similar factual patterns. *Herridge v. Board of Registration in Medicine*, 420 Mass. 154, 166 (1995). *Birudavol*, 448 Mass. at 1033 n.2 (concluding indefinite

suspension permissible absent evidence that this outcome was "inconsistent with sanctions imposed on other doctors in similar circumstances"). The burden is on the petitioner to demonstrate error. *Fisch*, 437 Mass. at 131.

3. Discussion.

a. Appropriate sanctions.

The record amply supports the Board's finding that the petitioner engaged in disruptive conduct, 243 Code Mass. Regs. § 1.03(5)(a)(18), in violating its Disruptive Behavior Policy 01-01, and that the petitioner's conduct thus undermined public confidence in the practice of medicine. "Conduct which undermines public confidence in the integrity of the medical profession is an independently sufficient ground for the board to sanction a physician." *Sugarman v. Board of Registration of Medicine*, 422 Mass. 338, 343 (1996).

As set forth *supra*, in determining the appropriate sanction for conduct that undermines public confidence in the integrity of the medical profession, the Board has broad discretion. *See Sugarman*, 422 Mass. at 347-348. As the Board notes in its final decision, "reprimand" is often the appropriate sanction for disruptive behavior. Indeed, reprimand was the sanction imposed in 2012 when the petitioner previously engaged in disruptive behavior undermining public confidence. Given, however, that the petitioner has continued in this behavior, the Board reasoned that the more severe sanctioned it issued was apt even in light of mitigating circumstances that it considered. *See In the Matter of Peter J. Mulhern, M.D.*, Board of Registration in Medicine, Adjudicatory

Case Nos. 2005-007, 2006-046 (Final Decision and Order, Sept. 5, 2007) (multiple instances of disruptive behaviors involving multiple co-workers on different days sanctioned by indefinite suspension).[2]

Based on a review of past decisions by the Board imposing sanctions in similar factual circumstances, consideration of the entire record, and in light of the deferential standard of review, the petitioner has not shown that the Board's sanction of an indefinite suspicion was arbitrary and capricious or an abuse of discretion. Moreover, having reviewed the entire record and considered the petitioner's other arguments, none have merit as discussed in the Board's opposition.

4. Conclusion.

Upon consideration thereof, it is hereby ORDERED and ADJUDGED that the final decision and order of the Board of Registration in Medicine is AFFIRMED.

/s/ Dalila Argaez Wendlandt
Dalila Argaez Wendlandt
Associate Justice

Entered: May 11, 2022

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[2] Notably, as the Board's final decision and order made clear, the petitioner can petition to stay the suspension after he (i) completes a new evaluation by Physician Health Services and follows its recommendations, (ii) completes a Board-approved course in anger management, and (iii) completes a Board-approved course in conflict management.

APPENDIX C
FINAL DECISION AND ORDER OF THE MASSACHUSETTS BOARD OF MEDICINE (MAY 20, 2021)

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

MIDDLESEX, SS

IN THE MATTER OF
SHELDON SCHWARTZ, M.D.)

Adjudicatory Case No. 2015-037(RM-15-648)

This matter came before the Board for disposition on the basis of the Board of Registration in Medicine's April 8, 2021 Partial Final Decision and Order as to Findings of Fact and Conclusions of Law Only (Partial Decision), incorporating the Administrative Magistrate's December 29, 2020 Recommended Decision. After full consideration of the Partial Decision, which is attached hereto and incorporated by reference and the Parties' Memoranda on Disposition, the Board adds the following:

Sanction

The record demonstrates that the Respondent has engaged in conduct that undermines public confidence in the integrity of the medical profession and has engaged in misconduct in the practice of

medicine. As a function of this Board's obligation to protect the public health, safety, and welfare, it is proper for the Board to discipline the Respondent. *See Levy v. Board of Registration in Medicine,* 378 Mass. 519 (1979).

The record reflects that the Respondent, an internist at Arhour-HRI Hospital (the Arbour) between 2005 and 2013, engaged in disruptive behavior on two days, three months apart, in 2013. On February 28, 2013, the Respondent, in the course of voicing patient safety concerns associated with continuing admissions while the electronic medical record system was down, called one administrator (Administrator 1) "a bitch" and told a second administrator (Administrator 2) that she was "corporate now" and he could "buy and sell [her] a million times." The Respondent apologized to patients in a group therapy session when told they could hear him speaking with Administrator 1.

On May 30, 2013, the Respondent, when asked to move from an examination room that also served as his office, and where he was entering orders, so that mental health workers could perform a "johnny search," said "No." Later that day, the Medical Director and the Respondent argued loudly in front of the nurses' station. When the Respondent was told that a patient could hear them, the Respondent said, "I don't care." The following day, the Respondent admitted that he had been disruptive and apologized to the mental health workers.

This Board recognized the association between disruptive behavior and patient safety long before adopting Board Policy Number 01-01 "Disruptive Physician Behavior." *See In the Matter of Kwok Wei*

Chan, MD., and Mohan Korgaonkar, MD., Board of Registration in Medicine, Adjudicator Case No. 94-20-XX (Consent Judgment, November 17, 1993)(the Board admonished, fined, and required joint therapy for two physicians who swore, threw an instrument, and scuffled briefly in an operating room). *See also In the Matter of Umer Sayeed-Shah, MD.,* Board of Registration in Medicine, Adjudicatory Case No. 00-22-XX (Consent Order, June 14, 2000)(the Board admonished and fined a physician who had engaged in a long standing dispute about various hospital policies, had been placed on probation by the hospital, and discharged his frustrations on a patient's family member, a janitor, and a physician who failed to call for a consultation.)

The Board has imposed sanctions ranging from admonishment to license suspension for disruptive conduct. The Board has consistently considered: the nature and number of disruptive acts, patterns in a physician's misconduct, and the context of the disruptive acts.

The Board has imposed an admonishment, when a physician who struck another physician and a nurse on the back during an operation intending to restore quiet in the operating room for the well-being of the patient. *See In the Matter of James Philip, MD,* Board of Registration in Medicine, Adjudicatory Case No. 2008-046-DALA (Final Decision and Order, March 16, 2011).

The Board most often imposed a reprimand for disruptive behavior and has imposed this sanction in wide-ranging circumstances, including: i) a case where a physician, frustrated by his facility's admitting patients he believed should be transferred to other

hospitals, refused to go into the hospital when contacted by nurses. *See In the Matter of Timothy Soul-Regine, MD.,* Board of Registration in Medicine, Adjudicatory Case No. 2013-042 (Consent Order, September 11, 2013); and ii) a case where a physician engaged in disruptive behavior on four separate occasions, including one where he threatened violence, but had completed a behavioral assessment, engaged in psychotherapy, and completed a course in workplace conflict prior to the imposition of discipline. *See In the Matter of Paul Silverstein, MD.,* Board of Registration in Medicine, Adjudicatory Case No. 2007-066 (Consent Order, December 19, 2007).

In some instances, the Board has imposed indefinite suspension of a physician's license based on disruptive behavior and allowed a petition to stay the suspension upon the physician's entry into a Probation Agreement. See *In the Matter of Peter J. Mulhern, MD.,* Board of Registration in Medicine, Adjudicatory Case Nos. 2005-007 and 2005-046 (Final Decision and Order, September 5, 2007)(the Board suspended the physician's inchoate right to renew his license and conditioned a petition to stay on the physician's demonstrate his fitness to practice and entering a Probation Agreement, where the physician's disruptive behavior included multiple acts on multiple days and included his throwing a sandbag in anger and injuring a co-worker's foot, and threatening to punch another physician).

When determining the appropriate sanction, the Board has considered a physician's history of "past misconduct essential in determining the appropriate level of discipline to be imposed." *See In the Matter of Saab,* 406 Mass. 315, 327-328 (1989). In the pendant

case, the Board disciplined the Respondent in 2012 based on conduct minoring his 2013 disruptive behavior. *See In the Matter of Sheldon Schwartz, MD.,* Board of Registration in Medicine, Adjudicatory Case No. 2012-024 (Consent Order, September 19, 2012)(the Board reprimanded the Respondent for December 2010 conduct, which included his placing his hand on the arm of the nursing supervisor and removing her from the room where he was entering patient orders and which she needed to examine a patient and later arguing in the presence a patient).

When determining the appropriate sanction in this matter, the Board acknowledges the Respondent is "an excellent clinician . . . [who] believes in the paramount importance of patient safety."[1] The Board observes, however, the Respondent's repeated use of aggressive behavior (swearing, verbally belittling, and using physical contact) when attempting to resolve systemic conflicts (a malfunctioning records system and the mixed use of a room for entry of patient orders and "Johnny searches") and his difficulty in resolving them through other mechanisms. The Board notes that the pattern continued following the Respondent's prior discipline by the Board for like behavior.

The Board acknowledges mitigating factors in this matter, namely: i) the Arbour "was a troubled workplace on many levels"[2] and the Respondent's behavior "was more of a symptom of larger problems

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[1] *See* Recommended Decision at p. 25.

[2] *Id.*

than the cause;"[3] and ii) the Division of Administrative Law Appeals closed the record in this ease on October 17, 2016 and issued a Recommended Decision on December 29, 2020.

Based on the pattern in the Respondent's use of aggression and past Board discipline, and in light of the mitigating factors identified, the Board hereby INDEFINITELY SUSPENDS the Respondent's license to practice medicine. Any petition to stay the suspension is conditioned upon the Respondent's documenting his completion of: i) a new evaluation by Physician Health Services (PHS) and following all recommendations made by PHS; ii) a Board-approved course in anger management; and iii) a Board-approved course in conflict management. The sanction is imposed for each violation of the law, and not a combination of any or all of them.

The Respondent shall provide a complete copy of this Final Decision and Order, with all exhibits and attachments, within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in-or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which he practices medicine; any in-or out-of-state health maintenance organization with whom he has privileges or any other kind of association; any state agency, in- or out-of-state, with which he has a provider contract; any in-or out-of-state medical employer, whether or not he practices medicine there; the state licensing boards of all states in which he has any kind of license; the Drug Enforcement Administration—Boston

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[3] *Id.*

Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which he becomes associated in the year following the date of imposition of this Final Decision and Order. The Respondent is further directed to certify to the Board within ten (10) days that s/he has complied with this directive.

The Respondent has the right to appeal this Final Decision and Order within thirty (30) days, pursuant to G.L. c. 30A, §§ 14 and 15, and G.L. c. 112, § 64.

/s/ George Araham, M.D.
M.D. Chair

Date: May 20, 2021

APPENDIX D
COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE POLICY 01-01 (JUNE 13, 2021)

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
POLICY 01-01 (Adopted June 13, 2001)

DISRUPTIVE PHYSICIAN BEHAVIOR

The Board of Registration in Medicine ("the Board") recognizes the commitment of today's highly skilled and motivated physicians to the delivery of quality health care. As part of its ongoing effort to optimize patient care and support professional standards among licensees in Massachusetts, the Board provides information on topics of concern to its licensees. It does so in recognition of the fact that the most effective way to respond to a challenging issue in health care is through increased education and discussion.

The American Medical Association (AMA) has defined disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.[1] The recent Institute of Medicine study concluded that health care systems must promote teamwork, the free exchange of ideas, and a collaborative approach to problem solving if medical errors are to be reduced. Disruptive behavior by a physician has a deleterious

[1] AMA H-140.918 Disruptive Physician Policy

effect upon the health care system and increases the risk of patient harm.

The Board strongly urges physicians to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care.[2] Behavior by a physician that is disruptive, and compromises the quality of medical care or patient safety, could be grounds for Board discipline.

The Board also urges physicians to support their hospitals as they work to identify and manage disruptive physician behavior, by taking an active role in this process whenever possible.

NEW AMA POLICY

Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are now recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. In order to more clearly delineate conduct that is unacceptable, the AMA has adopted the definition of disruptive behavior set forth above. The AMA distinguishes this behavior from criticism that is offered in good faith with the aim of improving patient care. The AMA has also reminded physicians of their ethical obligation to recognize their responsibility not only to patients, but also to society, to other

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[2] *Id.* 2

health professionals, and to self. Physicians are urged to recognize that the symptoms of stress, such as exhaustion and depression, can negatively affect their health and performance, and are encouraged to seek the support needed to help them regain their equilibrium.

NEW JCAHO STANDARDS

On January 1, 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued new medical staff standards that require hospitals to implement a non-disciplinary process for the identification and management of matters of individual physician health. The Joint Commission has stated that health care organizations have an obligation to protect patients from harm, and that they are therefore required to design a process that provides education and prevention of physical, psychiatric and emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of potentially impaired physicians. The focus of this process is rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients. However, the standards also direct that if, at any time during this process, it is determined that a physician is unable to safely perform according to the privileges that he or she had been granted, the matter is forwarded to medical staff leadership for appropriate corrective action. Such action includes, but is not limited to, strict adherence to any state or federally mandated reporting requirements. Physician Health Services, a corporation of the Massachusetts Medical Society, has developed guidelines to assist hospitals in meeting the new JCAHO medical staff standards, entitled

"Guidelines for Establishing Hospital and HMO Physician Health Committees." These guidelines, which include relevant statutory and regulatory information, can provide guidance to a facility in the establishment of a medical peer review committee that exclusively addresses physician health issues.

CONCLUSION

Physicians, in their role as patient and peer advocates, must recognize their obligation to speak out when faced with disruptive behavior. They must consider that "the importance of respect among all health care professionals as a means of ensuring good patient care is at the very foundation of the ethics advocated by the AMA."

Physicians must recognize that disruptive behavior, if it directly impacts patient care or safety, may reach a threshold for discipline. Judiciously applied, such discipline has allowed institutions to function more smoothly while ultimately benefiting both the doctor and his patients. For any policy to function fairly, trust and cooperation, as well as disclosure, is necessary.

1) Disruptive behavior among physicians is recognized nationally as a problem that at its least is unnecessary, displays emotional instability or deeper problems and leads to poor morale; at worst it impacts directly on patient safety and is subject to discipline. Pursuant to the new JCAHO guidelines, every health care facility must have a mechanism for dealing with disruptive physician behavior.

2) Behavior that would not be tolerated in another work setting will not be tolerated in hospitals or other heath care facilities.

3) It is the ethical duty of all physicians to promote standards of professional behavior among colleagues. However, when lapses in behavior place patients at risk, such lapses and risks should be reported to the hospital's Quality Assurance Committee, which should record the events, the outcome, and steps to assure compliance and lack of repetition. In many cases, such behavior should also be reported to the Board, pursuant to M.G.L. c.112, § 5F.

4) A health care facility's curtailment of a physician's activity as defined by 243 CMR 3.02 is reportable to the Board of Medicine, pursuant to M.G.L. c.111, § 53B.

APPENDIX E
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

243 CMR 1.03: Disposition of Complaints and Statutory Reports

(1) Initiation. Any person, organization, or member of the Board may make a complaint to the Board which charges a licensee with misconduct. A complaint may be filed in any form. The Board, in its discretion, may investigate anonymous complaints.

(2) Complaint Committee. The Board may establish a committee known as the Complaint Committee to review complaints charging a licensee with misconduct. If the Committee or a Board Investigator determines that a communication does not relate to any of the matters set forth in 243 CMR 1.03(5), the committee or the investigator may refer the communication to the proper authority or regulatory agency.

(3)

(a) Preliminary Investigation. A Board Investigator shall conduct such preliminary investigation, including a request for an answer from the licensee, as is necessary to allow the Complaint Committee to determine whether a complaint is frivolous or lacking in either merit or factual basis. If, after a preliminary investigation of an anonymous complaint, the investigator determines that the anonymous complaint is frivolous or

lacking in either merit or factual basis, the anonymous complaint shall not be docketed, shall be filed in a general correspondence file, and shall remain confidential.

(b) Subsequent Inquiry, Investigation. After receipt and review of a complaint, if the Complaint Committee determines that the complaint is frivolous or lacking in either legal merit or factual basis, it may close the complaint. The Committee shall notify the person who made the communication of its determination and the reasons for it. As to other complaints, the Committee shall conduct, or cause to be conducted, any reasonable inquiry or investigation it deems necessary to determine the truth and validity of the allegations set forth in the complaint.

(4) Conference. To facilitate disposition, the Board or the Complaint Committee may request any person to attend a conference at any time prior to the commencement of an adjudicatory proceeding. The Board or Committee shall give timely notice of the conference, and this notice must include either a reference to the complaint or a statement of the nature of the issues to be discussed. (5) Grounds for Complaint.

(a) Specific Grounds for Complaints Against Physicians. A complaint against a physician must allege that a licensee is practicing medicine in violation of law, regulations, or good and accepted medical practice and may be founded on any of the following:

1. Fraudulent procurement of his or her certificate of registration or its renewal;
2. Commitment 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;
3. Conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions;
4. Practicing medicine while the ability to practice is impaired by alcohol, drugs, physical disability or mental instability;
5. Being habitually drunk or being or having been addicted to, dependent on, or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects;
6. Knowingly permitting, aiding or abetting an unlicensed person to perform activities requiring a license.
7. Conviction of any crime;
8. Continuing to practice while his or her registration is lapsed, suspended, or revoked;

9. Being insane;
10. Practicing medicine deceitfully, or engaging in conduct which has the capacity to deceive or defraud.
11. Violation of any rule or regulation of the Board;
12. Having been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those set forth in M.G.L. c. 112, § 5 or 243 CMR 1.03(5);
13. Violation of 243 CMR 2.07(15): Medicare Payments;
14. Cheating on or attempting to compromise the integrity of any medical licensing examination;
15. Failure to report to the Board, within the time period provided by law or regulation, any disciplinary action taken against the licensee by another licensing jurisdiction (United States or foreign), by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct substantially the same as acts or conduct which would constitute grounds for complaint as defined in 243 CMR 1.03(5);
16. Failure to respond to a subpoena or to furnish the Board, its investigators or representatives, documents, information

or testimony to which the Board is legally entitled;

17. Malpractice within the meaning of M.G.L. c. 112, § 61; 18. Misconduct in the practice of medicine.

(b) Other Grounds for Complaints Against Physicians. Nothing in 243 CMR 1.00 shall limit the Board's adoption of policies and grounds for discipline through adjudication as well as through rule-making.

(6) Docket. The Board shall assign a docket number to all complaints and shall mark the complaint with this number and the date filed. All subsequent papers relating to the particular complaint shall be marked with the same docket number and shall be placed in a file (the docket) with all other papers bearing the same number.

(7) Order for Answering and Answer. The Committee may order that the licensee complained of answer the complaint within ten days. The Committee shall attach a copy of the complaint to the order for answering or shall describe the acts alleged in the complaint. A licensee shall respond to an order for answering either personally or through his or her attorney, in compliance with 243 CMR 1.02(6). An answer must address the substantive allegations set forth in the complaint or order.

(8) Dismissal by Complaint Committee. Upon receipt of a licensee's answer or at any point during the course of investigation or inquiry into a complaint, the Committee may determine that there is not and will not be sufficient evidence to warrant further proceedings or that the complaint fails to

allege misconduct for which a licensee may be sanctioned by the Board. In such event, the Committee shall close the complaint. The Committee shall retain a file of all complaints.

(9) Board Action Required. If a licensee fails to answer within the ten-day period or if the Committee determines that there is reason to believe that the acts alleged occurred and constitute a violation for which a licensee may be sanctioned by the Board, the Committee may recommend to the Board that it issue a Statement of Allegations.

(10) Disposition by the Board. The Board shall review each recommendation which the Committee forwards to it within a reasonable time and shall require an adjudicatory hearing if it determines that there is reason to believe that the acts alleged occurred and constitute a violation of any provision of 243 CMR 1.03(5) or M.G.L. c. 112, § 5. The Board may take such informal action as it deems a complaint warrants. If the Board requires an adjudicatory hearing, it may refer the matter to a hearing officer.

(11) Suspension Prior to Hearing. The Board may suspend or refuse to renew a license pending a hearing on the question of revocation if the health, safety or welfare of the public necessitates such summary action. The procedure for summary suspension is as follows:

(a) Immediate and Serious Threat. If, based upon affidavits or other documentary evidence, the Board determines that a licensee is an immediate and serious threat to the public health, safety, or welfare, the Board may

suspend or refuse to renew a license, pending a final hearing on the merits of the Statement of Allegations. The Board must provide a hearing on the necessity for the summary action within seven days after the suspension.

(b) Serious Threat. If, based upon affidavits or other documentary evidence, the Board determines that a licensee may be a serious threat to the public health, safety or welfare, the Board may order the licensee to file opposing affidavits or other evidence within three business days. Based upon the evidence before it, the Board may then suspend or refuse to renew the license, pending a final hearing on the merits of the Statement of Allegations. The Board must provide a hearing on the necessity for the summary action within seven days after the suspension.

(12) Classification of Complaints. (Reserved).

(13) Assurance of Discontinuance.

(a) 243 CMR 1.03(13) shall apply to minor violations of 243 CMR 1.03(5), and, unless there is an allegation of patient harm, allegations of drug or alcohol impairment, as determined within the discretion of the Complaint Committee and the Board.

(b) At the time that the Complaint Committee determines that a recommendation for a Statement of Allegations is warranted, it may either forward such recommendation to the Board or refer the matter to a conference including a Hearing Officer, a representative of the Disciplinary Unit, and the

Respondent. At the conference, the representative of the Disciplinary Unit and the Respondent may submit to the Hearing Officer a proposed Assurance of Discontinuance, which shall include:

1. Recitation of Circumstances giving rise to the Assurance of Discontinuance,
2. The Respondent's assurance of discontinuance,
3. A sanction and/or the Respondent's agreement to pay the Commonwealth's costs of the investigation, and
4. The Respondent's agreement that violation of the Assurance of Discontinuance shall be prima facie evidence of violation of the applicable law, regulations or standards of good and accepted medical practice referenced in the Assurance of Discontinuance.

(c) If the Hearing Officer approves the Assurance of Discontinuance, it shall be forwarded to the Board for final approval.

(d) If the Hearing Officer and the Board do not approve an Assurance of Discontinuance within 60 days of referral of the matter to the Hearing Officer for conference, or if the Hearing Officer refers the matter back to the Complaint Committee, the Complaint Committee shall forward its recommendation regarding issuance of the Statement of Allegations to the Board.

(e) Pursuant to M.G.L. c. 112, § 2, the Board must report an Assurance of Discontinuance to any national data reporting system which provides information on individual physicians.

(f) The Respondent may request that the Board not process his or her case pursuant to 243 CMR 1.03, in which event the Complaint Committee shall forward its recommendation regarding issuance of a Statement of Allegations to the Board.

(14) Statutory Reports. The Complaint Committee, an investigator, and any of the Board's units may also review and investigate any report filed pursuant to M.G.L. c. 111, § 53B, M.G.L. c. 112, §§ 5A through 5I, or 243 CMR 2.00: Licensing and the Practice of Medicine and 3.00: The Establishment of and Participation in Qualified Patient Care Assessment Programs, Pursuant to M.G.L. c. 112, § 5, and M.G.L. c. 111, § 203. If the Board does not issue a Statement of Allegations based upon the statutory report, the statutory report and the records directly related to its review and investigation shall remain confidential. However, if such report and records are relevant to a resignation pursuant to 243 CMR 1.05(5), then they shall be treated like closed complaint files, under 243 CMR 1.02(8)(c) 1.; provided, however, that confidentiality of peer review documents is maintained in accordance with 243 CMR 1.02(8)(c)4. and that confidentiality of documents filed under M.G.L. c. 111, § 53B is maintained to the extent required by law.

(15) Discipline When License Has Been Revoked by Operation of Law. For purposes of administrative

economy and convenience, the Board may, in its discretion, defer commencement of formal disciplinary proceedings against a physician whose license has been revoked by operation of law under the provisions of M.G.L. c. 112, § 2 or through application of 243 CMR 2.06(2): Requirements for Renewing a Full, Administrative or Volunteer License. Such deferral may be until such time as the physician takes action to complete the renewal process. The Board shall notify the physician of its intent to defer action under 243 CMR 1.03(15); if the physician files a written objection within 60 days by certified, return-receipt mail, the Board shall not defer commencement of said proceeding. Nothing in 243 CMR 1.03(15) shall be construed to bar the Board from commencing disciplinary proceedings at any time, including any proceedings which may or may not have previously been deferred.

(16) Stale Matters. Except where the Complaint Committee or the Board determines otherwise for good cause, the Board shall not entertain any complaint arising out of acts or omissions occurring more than six years prior to the date the complaint is filed with the Board.

Mass. Gen. Laws Ch. 112 § 1

Section 1. The commissioner of public health shall supervise the work of the board of registration in nursing, the board of registration in pharmacy, the board of registration of physician assistants, the board of registration of perfusionists, the board of registration of nursing home administrators, the board of registration in dentistry, the board of registration of genetic counselors, the board of registration of community health workers, the board of registration in naturopathy, the board of registration of social workers, the board of registration of psychologists, the board of registration of allied mental health and human services professions, the board of allied health professions, the board of registration of dieticians and nutritionists, the board of registration in podiatry, the board of registration in optometry, the board of registration of dispensing opticians, the board of registration of chiropractors, the board of registration of speech-language pathology and audiology, the board of registration of hearing instrument specialists, the board of certification of health officers, the board of registration of sanitarians and the board of registration of respiratory therapists. He shall recommend changes in the methods of conducting examinations and transacting business, and shall make such reports to the governor as he may require or the director may deem expedient.

The commissioner of public health shall consult with the chair of the board of registration in medicine concerning the operations of the board.

APPENDIX F
BOARD'S DECLARATION TO THE U.S. NATIONAL PRACTIONERS DATA BANK (JUNE 2, 2021)

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

NPDB DCN: 5500000176189154

Basis for Initial action: Abusive Conduct Toward Staff (D4)

Initial Action: Suspension of License (1135)

Date of Action: 5/20/21

A. Reporting Entity

Entity Name: MA Board of Registration in Medicine
Address: 200 Harvard Mill Sq Ste 330
City, State, Zip: Wakefield, MA 01880-3239
Name or Office: Gerard Dolan
Title or Department: Assistant General Counsel
Telephone: (781) 876-8268
Type of Report: Initial

B. Subject Identification Information (Individual)

Subject Name: Schwartz, Sheldon E
Gender: Male
Date of Birth: 08/08/1946
Home Address: 5 Abernathy Rd
City, State, ZIP: Lexington, MA 02420-2510

Deceased: No
Social Security Numbers (SSN): ***- * *-1569
Professional School(s) & Year(s) of Graduation:New York University School of Medicine (1970)
Occupation/Field of Licensure: Physician (MD)
State License Number,
State of Licensure: 81429, MA
Specialty: Internal Medicine
Drug Enforcement Administration
(DEA): BS4516336
Names of Health Care Entity with Subject is Affiliated or Associated (Inclusion Does Not Imply Complicity in the Reported Action): Arbour HRI Hospital
Business Address of Affiliate: 227 Babcock St
City, State, ZIP: Brookline, MA 02446-6773
Nature of Relationship(s): Subject Has Clinical Privileges with Affiliate or Associate (350)

C. Information Reported

Type of Adverse Action: State Licensure
Basis for Action: Abusive Conduct Toward Staff (D4)
Name of Agency or Program That Took the Adverse Action Specified in This Report:
MA Board of Registration in Medicine
Adverse Action Classification Code(s):
Suspension of License(1135)
Date Action Was Taken: 05/20/2021
Date Action Became Effective: 05/20/2021
Length of Action: Indefinite
Description of Subject's Act(s) or Omission(s) or Other Reasons for Action(s) Taken and Description of Action(s) Taken by Reporting Entity: At its May 20, 2021 meeting, the Massachusetts Board

of Registration in Medicine issued a Final Decision and Order, suspending Dr. Schwartz's License.

Is the adverse action specified in this report based on the subject's professional competence or conduct, which adversely affected, or could have adversely affected; the health or welfare of patient(s)?: NO

E. Report Status

Date of Original Submission:	06/02/2021
Date of Most Recent Change:	06/02/2021

F. Supplemental Subject Information on File with Data Bank

The following information was not provided by the reporting entity identified in Section A of this report. The information was submitted to the Data Bank from other sources and is intended to supplement the information contained in this report.

National Provider Identifiers (NPI): 1457373078

This report is maintained under the provisions of: Section 1921

The information contained in this report is maintained by the National Practitioner Data Bank for restricted use under the provisions of Section 1921 of the Social Security Act, and 45 CFR Part 60. All information is confidential and may be used only for the purpose for which it was disclosed. Disclosure or use of confidential information for other purposes is a violation of federal law. For additional information or clarification, contact the reporting entity identified in Section A.

END OF REPORT