COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BEFORE THE STATE BOARD OF MEDICINE

PROTHONOTARY
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Department of State

Commonwealth of Pennsylvania, Bureau of Professional and Occupational Affairs	:	**File No. 09-49-12096**
v.	:	**Docket No. 0089-49-10**
Thomas M. Horiagon, M.D., Respondent	:	

COPY

FINAL ORDER

AND NOW, this 3rd day of June, 2010, the State Board of Medicine (Board), having reviewed the entire record of this case established before the hearing examiner, and noting that although the Board did file a Notice of Intent to Review, neither party filed an application to review, **ADOPTS** the Adjudication and Order of the hearing examiner as the Final Adjudication and Order in this case. A copy of the Adjudication and Order is attached as Attachment A.

This order shall be retroactive to April 27, 2010, the effective date of the hearing examiner's adjudication and order.

BUREAU OF PROFESSIONAL & OCCUPATIONAL AFFAIRS	STATE BOARD OF MEDICINE
Basil L. Merenda	Carol E. Rose
BASIL L. MERENDA **COMMISSIONER**	**CAROL E. ROSE, M.D.** **CHAIRPERSON**

Hearing Examiner: Ruth D. Dunnewold, Esquire

Respondent's Address: Thomas M. Horiagon, M.D.
[redacted]
[redacted]

Prosecuting Attorney: Keith E. Bashore, Esquire

Board counsel: Sabina I. Howell, Esquire

Date of mailing: June 3, 2010

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v.	:	**Docket no. 0089-49-10**
	:	**DOS File no. 09-49-12096**
Thomas M. Horiagon, M.D., Respondent	:	

ADJUDICATION AND ORDER

Ruth D. Dunnewold
Hearing Examiner

2601 North Third Street
Harrisburg, PA 17110

DISTRIBUTED 4-7-10
ECUTION
SEL
NG EXAMINER

ATTACHMENT A

HISTORY

This matter was initiated by the filing of an Order to Show Cause (OSC) alleging that Respondent Thomas M. Horiagon, M.D. (Respondent), violated the Medical Practice Act.[1] The OSC sets forth two counts, the first alleging that Respondent's medical licenses in the states of Iowa and Colorado have been disciplined by the respective state licensing boards, subjecting Respondent to disciplinary action under the Medical Practice Act (Act) at section 41(4), 63 P.S. § 422.41(4), and the second alleging that Respondent has failed to report these disciplinary actions to the State Board of Medicine (Board) as required under § 903(2) of the Medical Care Availability and Reduction of Error (Mcare) Act,[2] 40 P.S. § 1303.903(2), subjecting him to disciplinary action under that provision.

The Commonwealth filed its OSC on January 12, 2010. Respondent filed a timely response to the OSC. Subsequently, the Prothonotary's Office issued a Notice of Hearing in the matter, scheduling a hearing for March 22, 2010. The hearing was convened on the scheduled date, with the Commonwealth represented by Prosecuting Attorney Keith E. Bashore. Respondent appeared at the hearing and elected to proceed *pro se*. Respondent testified on his own behalf. Both parties waived the filing of post-hearing briefs and the record was closed with the filing of the transcript on March 30, 2010.

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[1]Act of December 20, 1985, P.L. 457, No. 112, *as amended*, 63 P.S. § 422.1 *et seq.*
[2]Act of March 20, 2002, P.L. 154, No. 13, *as amended*, 40 P.S. § 1303.101 *et seq.*

FINDINGS OF FACT

1. Respondent holds a license to practice medicine and surgery in the Commonwealth of Pennsylvania, license no. MD032456E. Board records.

2. Respondent's license is active through December 31, 2010, and may be renewed thereafter upon the filing of the appropriate documentation and payment of the necessary fees. *Id.*

3. At all relevant times, Respondent held a license to practice medicine and surgery in the Commonwealth of Pennsylvania. *Id.*

4. Respondent's home address, and his last known address on file with the Board, is [redacted] Board records; Notes of Testimony (NT) at 15.

5. Respondent obtained his undergraduate and medical education at Brown University and subsequently attended the Harvard School of Public Health, where he obtained a Masters of Occupational Health. Exhibit R-1 (Letter dated November 7, 2008, addressed to the [Colorado] State Board of Medical Examiners from Philip M. Bluestein, Attorney at Law, representing Respondent (hereafter referred to as "Bluestein letter")); NT at 13.

6. Respondent completed a residency in Internal Medicine at the University of Michigan, worked for three years at the Centers for Disease Control in the Epidemic Intelligence Service, and completed a pulmonary fellowship at the University of San Francisco. *Id.*

7. Respondent is Board-certified in Pulmonary Disease, Internal Medicine and Occupational Medicine. Exhibit R-1 (Bluestein letter, Iowa Board of Medicine Online Renewal System document dated 10-26-09).

8. Respondent is or has been licensed to practice medicine in at least seven states in addition to Pennsylvania, including California, Colorado, Indiana, Iowa, Massachusetts, West Virginia and Wyoming. Exhibit R-1 (Alaska State Medical Board Application for License to Practice Medicine or Osteopathy; Bluestein letter; Iowa Board of Medicine Online Renewal System document dated 10-26-09).

9. Respondent has primarily practiced as a locum tenens physician hospitalist and intensivist in the past but has recently changed his practice to settle in one place because of the potential, with locum tenens contract work, for any kind of disciplinary action to reverberate among multiple state boards. Exhibit R-1 (Bluestein letter); NT at 14.

10. Because of his practice as a locum tenens physician, Respondent has held privileges in at least 39 different hospitals and institutions. Exhibit R-1 (Bluestein letter).

11. Typically with a new locum tenens contract, Respondent must apply for hospital privileges. *Id.*

12. When Respondent completes a locum tenens contract, he resigns his hospital staff privileges, does not renew them and simply allows them to lapse, or maintains them so that he can return for a new contract at a later date. Exhibit R-1 (Bluestein letter); NT at 10.

13. From December 2003 to June 2004, Respondent worked as a locums tenens contractor for Clear Creek Medical Group, providing hospitalist, intensivist and pulmonary coverage services to a number of hospitals in the metropolitan Denver area. Exhibit R-1 (ONYX M.D. Provider Application Explanation of Disciplinary Actions); NT at 9 – 10.

14. One of the hospitals for which Respondent provided services through Clear Creek was Exempla Lutheran Medical Center in West Ridge, Colorado. Commonwealth Exhibit C-1, paragraph 3; NT at 9 – 10.

15. An issue arose at Exempla Lutheran Medical Center when a nurse complained that Respondent did not timely respond to her page and the complaint was routinely referred to the hospital administration. Exhibit R-1 (Letter dated March 26, 2009, addressed to the Alaska State Medical Board); NT at 10.

16. Respondent refused to attend a mandatory meeting concerning the matter unless he was permitted to be accompanied by his legal counsel. *Id.*

17. The hospital refused to allow Respondent to attend with counsel, taking the position that the meeting was not a "fair hearing" process. Exhibit R-1 (Letter dated March 26, 2009, addressed to the Alaska State Medical Board).

18. Without resolving the matter, Respondent resigned from Clear Creek in June 2004 because he believed the job requirements, covering five facilities in three different Colorado counties, were too intrinsically risky to continue. Exhibit R-1 (Letter dated March 26, 2009, addressed to the Alaska State Medical Board; ONYX M.D. Provider Application Explanation of Disciplinary Actions).

19. When Respondent left Clear Creek in June 2004, he completed his charts at the facilities he had covered, but he did not resign his hospital staff privileges because it was the policy of Clear Creek to request withdrawal of privileges at covered facilities on behalf of departing physicians. Exhibit R-1 (Letter dated March 26, 2009, addressed to the Alaska State Medical Board; ONYX M.D. Provider Application Explanation of Disciplinary Actions); NT at 10.

20. Respondent's privileges at Exempla were not resigned for him, and on February 14, 2005, while Respondent was on assignment in Riyadh, Saudi Arabia, Exempla terminated his privileges. Commonwealth Exhibit C-1; Exhibit R-1 (Letter dated March 26, 2009, addressed to

the Alaska State Medical Board; ONYX M.D. Provider Application Explanation of Disciplinary Actions); NT at 10.

21. Respondent was not aware of the termination of his privileges at Exempla. Exhibit R-1 (Letter dated March 26, 2009, addressed to the Alaska State Medical Board; ONYX M.D. Provider Application Explanation of Disciplinary Actions).

22. In 2007, Respondent applied for a medical license in the state of Iowa, listing all his active and previous hospital privileges on his application, but he was not aware of Exempla's termination of his privileges at that time. Exhibit R-1 (Bluestein letter); NT at 10 – 11.

23. During its routine check of Respondent's application information, the Iowa State Board of Medicine (Iowa Board) learned that Exempla had terminated Respondent's privileges. Exhibit R-1 (Bluestein letter); NT at 10 – 11.

24. The Iowa Board informed Respondent of Exempla's termination of his privileges and that was the first time Respondent was aware of the action. Exhibit R-1 (Bluestein letter); NT at 10 – 11.

25. Respondent resolved the matter with the Iowa Board by entering into a Consent Agreement in April 2007 which included a Citation and Warning as well as a civil penalty of $1000. Commonwealth Exhibit C-1; Exhibit R-1 (Bluestein letter); NT at 11.

26. Respondent did not understand the Iowa Consent Agreement to be a disciplinary action that was reportable to the National Practitioner Data Bank (NPDB). Exhibit R-1 (Bluestein letter); NT at 11.

27. The Iowa Board Consent Agreement was a disciplinary action and was reported to the NPDB. Commonwealth Exhibit C-1; NT at 11.

28. Later in 2007, Respondent submitted a Renewal Questionnaire to the Colorado State Board of Medical Examiners (Colorado Board). Commonwealth Exhibit C-2; Exhibit R-1 (Bluestein letter); NT at 11.

29. The Renewal Questionnaire asked "since you last renewed your Colorado medical license, have you been admonished, reprimanded, censured and/or disciplined in any way by any licensing agency in another state or country, by any peer review committee or body, by any health care facility or committee thereof, or by any professional or medical society or association or committee thereof, or by any governmental agency, law enforcement agency or court of law whether involuntary or in lieu of investigation? You must answer "YES" if any of these actions are currently pending. You must answer "YES" if you have withdrawn or failed to proceed with an application for these items." Commonwealth Exhibit C-2.

30. Because Respondent believed that the Iowa Consent Agreement was not a disciplinary matter, he answered "NO" in response to the above question on the Colorado Renewal Questionnaire, which he submitted May 8, 2007. Commonwealth Exhibit C-2; Exhibit R-1 (Bluestein letter); NT at 11.

31. On February 20, 2009, the Colorado Board issued a Letter of Admonition to Respondent for his failure to respond "YES" to the above question with regard to the Iowa Consent Agreement. Commonwealth Exhibit C-2; NT at 11.

32. The Colorado Board action was a disciplinary action. Commonwealth Exhibit C-2.

33. In a letter dated December 12, 2008, which Respondent sent to the Pennsylvania Board in conjunction with renewing his Pennsylvania license online, Respondent first disclosed the Iowa and Colorado Board actions to the Pennsylvania Board. Exhibit R-1 (Letter dated

December 12, 2008, addressed to the State Board of Medicine from Thomas Horiagon, M.D., M.O.H.).

34. Respondent is currently employed with a single specialty pulmonary group in Grand Junction, Colorado. NT at 14.

35. Respondent received the OSC filed in this matter, appeared at the hearing *pro se*, and testified and presented documentary evidence on his own behalf. NT at 5 – 6 and *passim*.

CONCLUSIONS OF LAW

1. The Board has jurisdiction in this matter. Findings of Fact 1 – 3.

2. Respondent received notice of this proceeding and was afforded an opportunity to be heard in accordance with section 4 of the Administrative Agency Law, 2 Pa. C.S. § 504. Finding of Fact 35.

3. Based on the actions by the Iowa and Colorado Boards, Respondent's license has been the subject of disciplinary action by the proper licensing authority in two other states, authorizing the Board to impose disciplinary sanctions on Respondent pursuant to the Medical Practice Act at § 41(4), 63 P.S. § 422.41(4). Findings of Fact 13 – 32.

4. Respondent failed to report the Iowa Board action to the Board within 60 days of its occurrence, violating the Mcare Act at § 903(2), 40 P.S. § 1303.903(2), and subjecting Respondent to the imposition of a civil penalty under the Mcare Act at § 908, 40 P.S. § 1303.908. Findings of Fact 25 – 27, 33.

DISCUSSION

Violations

Count One of this action is brought under the Medical Practice Act at section 41(4), 63 P.S. § 422.41(4), which provides as follows:

> **§ 422.41. Reasons for refusal, revocation, suspension or other corrective actions against a licensee or certificate holder**
>
> The board shall have authority to impose disciplinary or corrective measures on a board-regulated practitioner for any or all of the following reasons:
>
> * * *
>
> (4) Having a license or other authorization to practice the profession revoked or suspended or having other disciplinary action taken, or an application for a license or other authorization refused, revoked or suspended by a proper licensing authority of another state, territory, possession or country, or a branch of the Federal Government.
>
> * * *

When a violation of § 41 of the Medical Practice Act, 63 P.S. § 422.41, occurs, the Board is empowered to impose the disciplinary or corrective measures enumerated at section 42(a), 63 P.S. § 422.42(a), which states the following:

> **§ 422.42. Types of corrective action.**
>
> (a) **Authorized actions.**—When the board is empowered to take disciplinary or corrective action against a board-regulated practitioner under the provisions of this act or pursuant to other statutory authority, the board may:
>
> (1) Deny the application for a license, certificate or any other privilege granted by the board.
>
> (2) Administer a public reprimand with or without probation.
>
> (3) Revoke, suspend, limit or otherwise restrict a license or certificate.

(4) Require the board-regulated practitioner to submit to the care, counseling or treatment of a physician or a psychologist designated by the board.

(5) Require the board-regulated practitioner to take refresher educational courses.

(6) Stay enforcement of any suspension, other than that imposed in accordance with section 40, and place a board-regulated practitioner on probation with the right to vacate the probationary order for noncompliance.

(7) Impose a monetary penalty in accordance with this act.

Count Two of this action is brought pursuant to § 903(2) of the Mcare Act, 40 P.S. § 1303.903(2). The relevant portions of that provision state as follows:

§ 1303.903. Reporting

A physician shall report to the State Board of Medicine or the State Board of Osteopathic Medicine, as appropriate, within 60 days of the occurrence of any of the following:

* * *

(2) Information regarding disciplinary action taken against the physician by a health care licensing authority of another state.

* * *

Count Two, falling as it does under the Mcare Act, subjects Respondent to the imposition of a civil penalty of up to $10,000 under § 908 of the Mcare Act, 40 P.S. § 1303.908, as follows:

§ 1303.908. Licensure board-imposed civil penalty

In addition to any other civil remedy or criminal penalty provided for in this act, the [Medical Practice Act] or the [Osteopathic Medical Practice Act], the State Board of Medicine and the State Board of Osteopathic Medicine . . . may levy a civil penalty of up to $10,000 on any current licensee who violates any provision of this act, the Medical Practice Act of 1985 or the Osteopathic Medical Practice Act . . . The boards shall levy this penalty only after affording the accused party the opportunity for a hearing as provided in 2 Pa.C.S. (relating to administrative law and procedure).

The degree of proof required to establish a case before an administrative tribunal in an action of this nature is a preponderance of the evidence. *Lansberry v. Pennsylvania Public Utility Commission*, 578 A.2d 600, 602 (Pa. Cmwlth. 1990). A preponderance of the evidence is generally understood to mean that the evidence demonstrates a fact is more likely to be true than not to be true, or if the burden were viewed as a balance scale, the evidence in support of the Commonwealth's case must weigh slightly more than the opposing evidence. *Se-Ling Hosiery, Inc. v. Margulies*, 70 A.2d 854, 856 (Pa. 1949). The Commonwealth therefore has the burden of proving the charges against Respondent with evidence that is substantial and legally credible, not by mere "suspicion" or by only a "scintilla" of evidence. *Lansberry*, 578 A.2d at 602.

The Commonwealth charged in the order to show cause that Respondent's license to practice medicine and surgery in Pennsylvania is subject to disciplinary action because the Iowa and Colorado Boards disciplined his licenses to practice medicine in those states. Respondent admitted that the Iowa and Colorado actions occurred and did not deny that they constituted disciplinary actions. Additionally, the Commonwealth introduced and moved into the record at the hearing certified copies of the records from the other states' actions. Accordingly, the Commonwealth has met its burden of proof as to the allegations in Count One.

As to Count Two, despite the allegations contained there, the Commonwealth presented no evidence to indicate whether or not Respondent ever reported the Iowa or Colorado Board actions to the Pennsylvania Board. Respondent, however, in the materials he provided which were marked and admitted as Exhibit R-2, included a copy of a letter, dated December 12, 2008, in which he informed the Pennsylvania Board of the action by the Iowa Board and the *pending* action by the Colorado Board. Respondent makes no claim that he reported these actions prior to his renewal in December 2008. Accordingly, it is reasonable to assume, and it is more likely

than not, that Respondent first reported these actions to the Pennsylvania Board in December 2008.

The Iowa action occurred in April 2007, so Respondent's first reporting it in December 12, 2008, was clearly more than 60 days after it had occurred. The Colorado action, when Respondent reported it in December 2008, was only under consideration. It actually occurred by letter dated February 20, 2009. The record is silent as to whether Respondent subsequently reported the Colorado Letter of Admonition to the Pennsylvania Board. Therefore, the evidence is sufficient to demonstrate that Respondent failed to report the Iowa action to the Pennsylvania Board within 60 days of its occurrence, but is insufficient to demonstrate whether or not Respondent failed to report the Colorado Board's final action to the Pennsylvania Board with 60 days of its occurrence. Nonetheless, at least as to the Iowa Board action, the evidence is sufficient to prove the violation outlined in Count Two.

Penalty

The remaining issue is the appropriate penalty to be imposed. Under its enabling legislation, the Board is charged with the responsibility and authority to oversee the profession and to regulate and license professionals to protect the public health and safety. *C.f. Barran v. State Board of Medicine,* 670 A.2d 765, 767 (Pa. Cmwlth. 1996), *appeal denied* 679 A.2d 230 (Pa. 1996). In a reciprocal disciplinary case, it is common to impose a sanction that mirrors the action imposed in the other state, unless aggravation or mitigation evidence suggests a different penalty.

There is mitigation found, in this matter, in the fact that Respondent understood that the Iowa Board action was not disciplinary and was not to be reported to the NPDB. Indeed, the Commonwealth stated at the hearing in this matter that it was unclear why the Iowa Board's civil

penalty had been reported to the NPDB, for the matter appeared to be one that would not be so reportable.[3] NT at 18. The Commonwealth reinforced this understanding by recommending as the penalty in this matter only that Respondent be assessed a civil penalty of $1000, which the Commonwealth stated would not be reported to the NPDB, a recommendation which tacitly

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[3]The Code of Federal Regulations, which governs reporting to the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB), provides as follows at 45 C.F.R. Part 61:

§ 61.3 Definitions.

The following definitions apply to this part:

* * *

Any other negative action or finding by a Federal or State licensing agency means any action or finding that under the State's law is publicly available information, and rendered by a licensing or certification authority, including but not limited to, limitations on the scope of practice, liquidations, injunctions and forfeitures. This definition also includes final adverse actions rendered by a Federal or State licensing or certification authority, such as exclusions, revocations or suspension of license or certification that occur in conjunction with settlements in which no finding of liability has been made (although such a settlement itself is not reportable under the statute). ***This definition excludes administrative fines or citations and corrective action plans and other personnel actions, unless they are:***

(1) Connected to the delivery of health care services, and
(2) Taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation or surrender.

* * *

§ 61.7 Reporting licensure actions taken by Federal or State licensing and certification agencies.

(a) *What actions must be reported. Federal and State licensing and certification agencies must report to the HIPDB the following final adverse actions that are taken against a health care provider, supplier, or practitioner* (regardless of whether the final adverse action is the subject of a pending appeal)—
(1) Formal or official actions, such as revocation or suspension of a license or certification agreement or contract for participation in Federal or State health care programs (and the length of any such suspension), reprimand, censure or probation;
(2) Any other loss of the license or loss of the certification agreement or contract for participation in Federal or State health care programs, or the right to apply for, or renew, a license or certification agreement or contract of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewal (excluding nonrenewals due to nonpayment of fees, retirement, or change to inactive status), or otherwise; and
(3) Any other negative action or finding by such Federal or State agency that is publicly available information.

* * *

(Emphasis in boldface italics added). Therefore, a civil penalty alone, which is not connected to the delivery of health care services or taken in conjunction with other licensure actions, would not be reportable to the NPDB.

recognized the mitigation evidence in the record. Since this mirrors the sanction in Iowa, it is reasonable.

The question remains as to the appropriate sanction for Respondent's failure to report the Iowa Board action to the Board within 60 days, as required under the Mcare Act. The allegations in Count Two were not addressed by either party at the hearing, the Commonwealth did not present any evidence in proof of those allegations, and the Commonwealth recommended no sanction in connection with Count Two. While there is sufficient evidence in Respondent's own documentation to demonstrate that Respondent was late in reporting the Iowa action, (although no such evidence exists as to the Colorado action), the Commonwealth by its actions appears to have chosen not to pursue this count.

Respondent does reference, in some of his material, the difficulties inherent in holding licenses in multiple jurisdictions, and the fact that it is incumbent upon him to ensure that he understands what each and every medical board requires of him. Exhibit R-2 (Bluestein letter at page 3, item 3). Based on those references, it is clear that Respondent recognizes that his license is his property and that he has a responsibility to know the laws applicable to his property, *Heckert v. Dep't of State, Bur. of Prof'l & Occupational Affairs*, 476 A.2d 481 (Pa. Cmwlth. 1984), and that ignorance of the law is not an excuse. *Rankin against Mortimere*, 7 Watts 372 (Pa. 1838). Under the circumstances, while a technical violation of the statute has occurred with regard to the Iowa action, no additional sanction is required in order to emphasize for Respondent his responsibility to report other boards' actions to this Board within 60 days. Accordingly, based upon the above findings of fact, conclusions of law and discussion, the following order will issue: