Exhibit H

sixty-five hundred thirty of the education law, the director may direct that charges be prepared and served and may refer the matter to a committee on professional conduct for its review and report of findings, conclusions as to guilt, and determination. In such cases, the notice of hearing shall state that the licensee shall file a written answer to each of the charges and allegations in the statement of charges no later than ten days prior to the hearing, and that any charge or allegation not so answered shal the licensee may wish to seek the advice of counsel that the licensee may file a brief and affidavit professional conduct, that the licensee may app committee on professional conduct, may be repres present evidence or sworn testimony in his or her contain such other information as may be consi director. The department may also present evider file a brief at the hearing. A stenographic reco made. Such evidence or sworn testimony offe professional conduct shall be strictly limited to evi ing to the nature and severity of the penalty to be Where the charges are based on the conviction o jurisdictions, evidence may be offered to the commi the conviction would not be a crime in New York professional conduct may reasonably limit the n testimony will be received and the length of time ar to testify. The determination of the committee licensee and the department in accordance with t (h) of this subdivision. A determination pursuant reviewed by the administrative review board for pr

(q) At any time subsequent to the final conclusion of a professional misconduct proceeding against a licensee, whether upon the determination and order of a hearing committee issued pursuant to paragraph (h) of this subdivision or upon the determination and order of the administrative review board issued pursuant to paragraph (d) of subdivision four of section two hundred thirty-c of this title, the licensee may file a petition with the director, requesting vacatur or modification of the determination and order. The director shall, after reviewing the matter and after consulting with department counsel, determine in the reasonable exercise of his or her discretion whether there is new and material evidence that was not previously available which, had it been available, would likely have led to a different result, or whether circumstances have occurred subsequent to the original determination that warrant a reconsideration of the measure of discipline. Upon determining that such evidence or circumstances exist, the director shall have the authority to join the licensee in an application to the chairperson of the state board for professional medical conduct to vacate or modify the determination and order, as the director may deem appropriate. Upon the joint application of the licensee and the director, the chairperson shall have the authority to grant or deny such application.

11. Reporting of professional misconduct:

(a) The medical society of the state of New York, the New York state osteopathic society or any district osteopathic society, any statewide medical specialty society or organization, and every county medical society, every person licensed pursuant to articles one hundred thirty-one, one hundred thirty-one-B, one hundred thirty-three, one hundred thirty-seven and one hundred thirty-nine of the education law, and the chief executive officer, the chief of the medical staff and the chairperson of each department of every institution which is established pursuant to article twenty-eight of this chapter and a comprehensive health services plan pursuant to article forty-four of this chapter or article forty-three of the insurance law, shall, and any other person

James R. Caputo, M.D., F.A.C.O.G.
Board Certified in Obstetrics and Gynecology
1200 East Genesee Street • Suite 201
Syracuse, New York 13210 (315) 475-8599

July 10, 2013

Keith W. Servis, Director
Office of Professional Medical Conduct
New York State Department of Health
433 River Street, Suite 1000
Troy, NY 12180-2299

Re: BPMC Order #: 07-271
NYS Medical License #: 206065

Dear Mr. Servis,

Please accept this letter of petition requesting both a vacatur and a modification of a current Board Order with regard to my New York State medical license. This Order was the outcome of a matter adjudicated by the Department of Health between 2002 to 2008. It is with sincerity that the requests being made in this writing be received with true contemplation and understanding as to what is being asked. It will need your careful and perhaps repeated reading of this material to appreciate the level of concern that drives this meritorious effort. As you are aware, a great deal hinges upon your favorable response as the one person who holds the authority to then follow through with the current Chairperson of the State Board for Professional Medical Conduct to act accordingly. Understanding how monumentally busy your schedule must be, several thousand people (who stand to be impacted), are relying on the worthiness of this presentation to stir your heart to act on their, as well as my entire family's, behalf. So given the monumental importance of this matter to so many, your time and attention is honestly and truly appreciated.

The Issue in Summary: As a result of the above referenced Board Order in 2008, there have been a number of effects which have created a great deal of difficulty for my practice of medicine as an Ob/Gyn physician. As can be seen from the Order itself, three separate conditions were imposed upon my license. The first was a limitation to the license itself, particular to the use of high and mid forceps when performing a vaginal delivery. The second was a requirement to carry malpractice insurance coverage limits of $2 million/$6 million. And the third was the requirement of a practice monitor. The last two were to be enforced for a period of three years. These individual components will be addressed separately in order to illustrate precisely why, since being so commanded, each one has stifled (and really crippled) my ability to maintain gainful employment as a physician in New York, resulting in a tremendous detriment to my family. As such, pursuant to ***Public Health Law, Section 230(10)(q)***, it is my position that the petition that is to follow offers both **"new and material evidence that was not previously available which, had it been available, would likely have led to a different result"** along with "**circumstances which have occurred subsequent to the original determination that warrant a reconsideration of the measure of discipline"** and thus serve as the basis for the filing of this **"petition with the director, requesting a vacatur and/or modification of the determination and order."**

In addition to pointed argument and reason, this petition will make both references as well as directly discuss your statements as written in your March 24, 2011 response letter to me when, at that time even, I sought similar help from your office for similar reasons. In responding to some of your points, it will necessitate the occasional reference to already admitted evidence from the hearings, since this "material evidence" is pertinent to the discussion of these previous statements. The actual matter of my previous hearings is certainly over and done with and therefore no further argument of the issues will be entertained. However, given that I am directly entreating the authority of the director of this presiding State Office, some of the facts already in evidence need to be clear so as to appreciate the fairness and appropriateness of what is presently being asked regarding the substantial and moreover disproportionately punitive effects of the Board Order that indeed resulted from these hearings. Particular examples of admitted evidence are offered merely as another means of providing additional weight to the already meritorious contention being so submitted alongside it.

License Limitation in the areas of High and Mid Forceps Deliveries

This one component of my Order has created a most profound difficulty at sustaining any gainful employment in medicine. Therefore, submitted in support is new material evidence that is worthy enough to warrant a reconsideration and an appropriate modification to the Order as it pertains to this matter.

First, the degree by which adverse outcome continues to be personally and professionally experienced as a result of this imposed limitation mandates a little perspective to be illustrated. With all due respect to the past hearings, if you can, (for the moment), proportionally consider the real-life ***insignificance*** of what this official limitation on my license actually represents to the medical practice of Obstetrics alone (not to mention the addition of the whole of Gynecology), it is then difficult to understand how this clinically negligible restriction on an already rare procedure (which is even more rarely performed) could undermine an entire medical career, as it has in my case. Having been limited from performing a procedure that amounts to less than 0.1% of what is encountered across the entire spectrum of Ob/Gyn, only to have it literally wipe-out the remaining 99+% is just plain wrong. The reason that this **is** the case is because of the actual word "limitation" being associated with my license. It turns out that if **the word** is there, then you are excluded, denied, shut-out – from almost everything. This is even regardless of the fact that the true "limitation" itself (in this case) is clinically irrelevant for not only me but would be for any Ob/Gyn in being able to fully care for any given patient.

In my case, the impairment experienced in all areas of being able to gainfully work has proven to be from the word itself and not the contextualized inconsequentiality of what the limitation is in reality. Because if the latter were the case, the insignificance of the restriction would be otherwise clearly visible upon suitable explanation of both the facts and clinical relevance such that common sense would then rule and the issue gotten past. While the Board indeed has a duty to protect the public, how its disciplinary action is implemented has shown to be critical to the future employability of any given physician, as will be further explained.

Regardless of whatever issue any given doctor faces with the Department of Health, (DOH), by and large, physicians earnestly offer their best when providing care to their patients and have, (as we all know), invested years of education and training in order to sustain this profession for a lifetime. It should not be an automatic consequence of a Board Order, therefore, to render any doctor, who might otherwise have had an unfavorable interaction with the DOH, essentially unemployable for life due to what boils down to be (in many cases) a labeling issue. Especially when no prior allegation (disputed or not) was ever so odious to warrant such a devastating end result. This is what has been encountered in my experience and by many others I imagine.

When considering just what my limitation is in reality – clinically that is – then the real-life penalty that has literally come with it, (again, due in large part to the word "limitation" itself, which continues to nullify any potential endeavor as a physician), is monstrously out of proportion with what was intended by the DOH as well as what was in evidence leading to this determination in the first place, regardless of which side one might be representing.

In order to be able to sustain any sort of practice of medicine, one needs patients. In order to be able to see patients, one must be participating with any number of various health insurance carriers. Of course, liability insurance is imperative as well. And lastly, depending on a particular physician's specialty, they might also require hospital privileges. All of these requisite components to medical practice require credentialing and are not only encumbered whenever there is a restriction on one's medical license, but in many cases, it becomes impossible to successfully navigate the process at all due to this glaring label. No amount of explanation and appeals are sufficient enough to overcome this hard and fast policy by many institutions, corporations as well as our own Federal Government. If you have any sort of "limitation", you are not welcome – regardless of what the limitation actually is – even if it is clinically irrelevant, as I have mentioned perhaps half a dozen times already – (please forgive the necessary emphasis). The moniker of "damaged goods" is really that profound and far reaching. But more than that, it is unfair and undeserved. And again, what's all the more distressing with my case in particular is that my license restriction is for two procedures that have absolutely no bearing whatsoever on my ability to safely and effectively practice my entire specialty and are pretty much never encountered or ever need to be carried out given the availability of cesarean section as the most widely used alternative. Yet, despite the inconsequentiality of the entire thing, as you will soon understand, my practice has been made nearly impossible to sustain as a result of the stigma which bears this name "limited license".

This last point needs to be expounded upon just a little more in order to truly understand the substance of this component of my petition. Please follow along. Per the Board Order, I have been limited (or restricted) from using "high forceps" and "midforceps" (the latter for both deliveries and rotations of the baby – understandingly very complex issues). For the sake of reference, the level of descent of the baby's head in the birth canal is what determines the type of forceps (mid vs low vs outlet) when implementing these instruments. What's important to understand is that the first restricted type (high forceps) have already been *unofficially* outlawed from <u>within</u> the specialty itself for nearly four decades; they have never been a part of my clinical practice; and they were never mentioned nor the subject of any interest in all of my past interaction with the Department of Health. A restriction from using "high forceps" should therefore not even be listed as a limitation at all since they are already forbidden. All this limitation does is provide more negative perception, especially for those who don't understand these things.

This leaves the midforceps (deliveries and/or rotations) as the one true clinically applicable limitation in my case. In order to tangibly appreciate the (real life) insignificance of this limitation as well, it must be clarified as to just how infrequently encountered this procedure is in all of Obstetrical medicine. This is really critical to understand in all of this. First of all, forceps deliveries are seldomly done anymore anyway – chiefly because no one is being trained in them. So, of all the Obstetricians practicing in NY State alone, an educated guess would be that only 5% are still *actively* implementing forceps as part of their practice. The other 95% either opt for the vacuum device as the only other (and much less effective) alternative for assisted vaginal delivery or just do a cesarean section whenever faced with a clinical situation that would call for these decisions. A decision like this for assisted (or operative) vaginal delivery comes up perhaps once in 10 – 30 deliveries (perhaps more), given the unpredictable and highly variable

nature of Obstetrics. Yet, of those who still use forceps for these limited number of clinical circumstances, the "low" and "outlet" classification of forceps comprise nearly 98% of attempted cases. [Incidentally, my license **remains approved** for these two types.] This leaves an extremely small number of potential midforceps scenarios that might even be encountered as the only other kind that actually applies to my limitation situation. What's more is that there are even fewer forceps using physicians in the State who possess the skill to even carry-out this advanced option. All others, (those who don't use forceps at all, or just don't use mid forceps or even don't use vacuum), simply perform a cesarean section. And this is a significant percentage of Obstetricians as well. So again, to have two limitations: one from doing something that is already outlawed and a second which is so rarely encountered and even more uncommonly implemented because a more widely acceptable alternative (that being cesarean section for which I have no restriction) is readily available, the only purpose this present limitation is serving is to detriment my ability to work as a duly licensed, board certified physician in New York State simply by the label being there, when in reality it represents essentially nothing clinically relevant to the effective practice of Obstetrics and Gynecology. Please see this point as clearly as it is.

As a result of being restricted from performing a procedure that is so rare that I might have to go two years before having a clinical encounter so as to even apply the limitation in the first place, the damage cannot be understated. I have been directly excluded from six major insurance carriers as a result of this "limitation" being present on my license as their only reason. It is apparently company policy to exclude anyone with such a label. No exceptions. This is even after submitting written statements as to the clinical unimportance of this limitation in being able to fully practice my specialty (as argued above). To add to the difficulty, I have been outright excluded from applying to the medical staffs of two of the three hospital's in my community because they each have a specific policy barring any applications by anyone with a limited license. One of them is actually a New York State owned and run teaching institution where I am not only an alumnus but where I was previously on staff for more than ten years! Now only to be excluded. And this exclusion is not subject to any appellate rights within the institution either. In other words, you're out and you can't even appeal the issue. The same applies for liability insurance carriers as well. The limitation has automatically excluded me from two of the three admitted carriers in NY State. As for jobs themselves, even places that are otherwise eager or desperate for a physician are not even possible options for me. For example, I couldn't even apply for work on an Indian Reservation because the federal government has a strict policy about any limitation on a license being an automatic exclusionary criterion.

Hopefully, you can thus far appreciate the magnitude of the impact and the extensive reach that can result from these otherwise well-intentioned Board Orders. Surely the DOH has a duty to protect the public from bad medicine which I'm not even claiming is applicable to my case, but regardless, somewhere in all of this should also be what is personally *good for* and moreover, *desired by* the public/patient. One significant benefit or desire for any patient is to have their longstanding doctor available to them so long as he/she is deemed fit to practice. I have met this designation of fitness yet due to the limitation on my license, my availability is not only null for a great many patients who wish to return, it is in jeopardy of being indefinitely vanquished for all. Realizing that the Board has their interest in the matter to uphold as well, I request the following ***modification*** to my Order in this area of license limitation which will then have an effect only on the "appearance" of my license while continuing to satisfy the specific restrictions.

Considering the information from above describing the detriment to my practice, heightened by the actual non-applicability of the imposed limitations to both the full practice of Obstetrical medicine as well as my own practice, I ask that they be removed. They have no bearing

whatsoever on my practice of medicine (or any Obstetrician's for that matter) that they should remain in place on my license. It is like putting a restriction on a particular Nascar driver's license for knitting while he is racing. It's something that he will never do while engaging in his day-to-day profession, so it's meaningless, right? That's until he tries to enter his next race and encounters the hard line policy that states any driver with a limitation on his/her license is ineligible. It matters not if it was for the ridiculous notion of knitting while racing, a limitation is a limitation and thus you are out. Case closed. Strange analogy but it illustrates the point well.

To be clear though, I am not asking for the terms of the license limitation to be abandoned as they are not only straight forward to comply with but also signify the standing decision from the hearing (and thus the Board) itself. However, I am fully prepared to sign whatever statement/agreement necessary (please see attached) that continues to sustain the current forceps limitations and prohibitions to my license while simultaneously removing the wording from the official documentation. The agreement should also require me to eliminate and/or forego midforceps from any and every staff delineation of privilege list or application and provide documentation to the Board for each applicable hospital of this having been done (or established). In essence, I will never be able to perform another midforceps delivery again since there would be both a standing agreement between us as well as no hospital privileges at all for being able to do one. This was the objective of the Determination and will forever be satisfied. As for high forceps deliveries - as stated earlier, they are already outlawed and thus no one has (or ever will have) sanctioned privileges to do them. The agreed upon language should even state that I am to immediately surrender my license if at any time in the future, via any investigative means, I am legitimately found to have violated this accord as it pertains to mid and high forceps – the precise terms currently. With the fundamental purpose of my Board Order being to eliminate a certain type of forceps delivery from my practice while otherwise approving me to move on in my medical career, I urge you to consider this request since it accomplishes all of it. With my current state of affairs, this once intended expectation of simply moving on from my experience with the DOH is monumentally askew from reality and hence the driving force behind this petition.

I do not want to neglect addressing any pertinent points made by you in your previous letter. Pertaining to this issue specifically, you pointed out the ARB's conclusions. Again, this is not the forum to re-contend the allegations. I will say that in evidence is the following. First, at no time in any case where I clinically determined (via my experience, opinion and/or skill level) that the use of forceps was prudent was any mother or baby unduly harmed. Never. Secondly, as for the use of forceps after the hospital limited me for six months, in evidence is the fact that the hospital was indeed compelled to modify this restriction thus allowing supervised performance during the imposed time frame. When the sanctioned term was up, all privileges were returned without limit since no violation of the restriction was alleged by those who imposed it. Nonetheless, as already written, I am not asking for a complete vacatur of these terms of the Order, just a restructuring of how it appears.

Therefore, with the submission of the documents showing repeated denial of participation with both health insurance companies as well as admitting institutions, along with the profound and lasting financial detriment due to my inability to sustain any sort of employment in medicine, I believe that new and material evidence exists and circumstances have occurred subsequent to the original determination that warrant reconsideration of this measure of discipline. It is argued that had the State been able to foresee the fact that five years following the relatively small scale of limitation which was actually imposed upon this subject's license that he would be penniless, jobless and unemployable as a result of it all, then they might very well have opted for a different means to achieving their ends – hence, the submitted proposed agreement. Thus, because of

these circumstances, a reconsideration is warranted as to the measure of the discipline. The proposal put forth herein satisfies both the interests of the State as well as the petitioner in order that your consideration might be received.

Liability Insurance limit requirements of 2M/6M

Perhaps equally as critical to my present ability to practice medicine has been the matter of liability insurance. In fact, at the present time, it is the most pressing issue. I understand clearly from your previous letter that PHL 230 (18)(b) mandates the limits stated. Yet, the requirement to have double the malpractice insurance coverage has had the greatest impact overall on my ability to sustain my career. It was the very reason why my first attempt at reestablishing a practice following the original Board Order failed after only six months due to the excessive premium, combined with limited patient accessibility due to insurance carrier credentialing denials stemming from the license "limitation" issue detailed above. All of these factors remain in play today and are once again seriously jeopardizing the practice, especially now when a new liability insurance policy is due.

Notwithstanding the differences of opinion as to the clinical arguments set forth during my State hearings which led to the Board Order, there is one fact that remains and is undeniable by either side. And it is this: Not one person or baby has ever been unduly harmed by my practice of medicine and in particular, these very cases involving the Order in question. Nor was one penny awarded to any of the subject patients, three of whom actually availed themselves to testify on my behalf. All the cases involved were of a type that is either very infrequently encountered (and now obsolete for me given the forceps limitation), extremely atypical or even odd. Nevertheless, for each patient case, the outcomes were all good. In other words, (and this is very important) despite the arguments entered at the hearing and the language in the final determination, the bottom line is that no one was negligently hurt nor was there legal liability as a consequence of the care rendered in these cases.

Therefore, outside of the mandate in the law, it is truly difficult to understand why (in this case) there would even need to be a double malpractice limit requirement as a result of these unarguable points. With the likelihood of ever seeing any similar cases as the ones involved in the hearings being remote at best, the imposition of this increased liability insurance requirement seems a bit unsuitable, considering my malpractice history for the entirety of my career as a physician had been otherwise spotless and my clinical performance amongst the best in the community. As stated, this requirement has been the single greatest obstacle to practicing since essentially all other components of running a practice depend upon having a policy in place before those can proceed. I believe that this is an example of where the intention and application of the law can sometimes be a little disengaged from its real-life consequences. This is not a condemnation of the law itself but a specific case where appropriate argument is offered allowing the safeguards in PHL 230 (10)(q) to then be effectively exercised to the satisfaction of all parties.

As it stands, the real-life problem with this double liability insurance portion of the Order is two fold. First is finding anyone who can write for it and second is cost. Perhaps this is not fully appreciated by the Board (or the law) when imposing such a mandate but one cannot just dial up whatever coverage limits he wants and then just pay the premium. There are established industry standards for coverage limits and the double requirement imposed upon me is not one of them. For example, you cannot order a seven cylinder car. They do not exist as part of the normal production platform, regardless of whether some company could physically make one or not. It's the same with insurance policies apparently. Please see accompanying copy of an email from a veteran broker in Philadelphia whose company has extensive experience in this field and

who has helped me in the past when no one else could. She just about sums up the fact that there are literally no carriers but one who will write for 2M/6M coverage with the premium correspondingly coming at a significant cost along with a host of other stipulations. You might well imagine my interest in recently learning from my Probation Official in Albany that many monitored doctors are also experiencing extreme difficulty with these insurance limits.

There are a few rationales as to why I believe the law sees fit to impose these increased insurance limits in these OPMC matters. First, as stated above, the Legislature are likely not aware of how nearly impossible it is in general to obtain such coverage limits. Second, for some reason, by increasing the limits, it is possibly thought that by doing so, it will offer some degree of built in protection for the public. Yet, the current limit minimum of $1Million/$3Million has proven effective and sufficient in providing *appropriate* patient damages for years, even for those physicians who have high risk practices and/or who have past performance issues, the likes that grieve underwriters. There are even the enhanced limits available with 1.3M/3.9M coverage. So, it is not clear as to what the intent of the increased limits was in formulating the law. Certain physicians, who are fortunate enough to have <u>specific conditions</u> met, can also obtain excess insurance coverage (in addition to their own policy) through their admitting hospital at no extra charge. By having the required 1.3M/3.9M coverage already in place, the excess consists of an additional 1M/3M coverage. This would therefore give that particular provider over 2M6M coverage.

This third point is where I believe the law and the Board might be unaware of the logistics which surround access to this additional (excess) coverage through the hospital and thus feel it readily obtainable so as to be able to straightforwardly comply with such a component of a Board Order. When meeting with a few members of the Board in person back in 2008 after the Order was imposed, I inquired as to how they might suggest obtaining such limits. Their answer was, "It's quite simple really. Just get your base policy and then with the hospital's excess, this will put you over the requirement." It was quite matter of fact and clearly the main avenue by which the DOH felt this part of the Order was to be satisfied. Seemed simple enough at the time – especially, if you had a policy with one of the "admitted" carriers in the State who are the <u>only ones</u> who have access to the excess funds. This would also require you to be on staff at a hospital as well in order to tap into these funds so long as the other stipulations were met.

These conditions are what I believe the law/Board had (has) in mind as being readily available when these double limits were (are) imposed. The problem is that there is only a narrow set of circumstances whereby one can even qualify for these additional monies through the hospital. First, as mentioned, there are only three, (what is called), "admitted" liability insurance carriers in New York State who then are able to access these excess State funds through the hospital. Two of these three carriers automatically reject any application from me due to the aforementioned license limitation that exists. The third is the insurance pool where the cost is so prohibitively high that it already put me out of business previously as I continue to try and reconstruct this remnant of a once thriving career. Further, in order to qualify for these excess funds, one must also have had 1.3M/3.9M coverage in place for three consecutive years prior to applying for the excess. I do not qualify for this.

Thus, outside of obtaining the double limits via the excess coverage through a participating hospital and one of the three admitted carriers for NY, the only other option for satisfying the Order is to see if there is an RRG (Risk Retention Group) who is licensed in NY who can write for a whopping 2M/6M policy. As stated above, such a policy just doesn't exist. Only one carrier in the nation (with access to the NY market) was capable of fabricating something. Cost and payment options have proven excessively prohibitive and will shut down this practice once

again if a cost effective solution is not found. In order to sustain any sort of policy, I have had to scale back on coverage for certain procedures which then impacts revenue, which in turn again impacts what can be afforded as far as coverage goes. As is clearly visible, this vicious cycle moves in a negative direction. In her letter, the agent at Cornerstone Insurance Brokerage made it clear that if the limits were of a standard amount, even the enhanced limits of 1.3/3.9, then it would be straight forward to find a policy, even with all the past issues. This doesn't mean that the premium wouldn't be affected accordingly; it is just that the policy itself is more attainable. Certainly, if I met the criteria for being able to obtain the hospital based excess coverage, I would do so. It has been rumored, however, that this excess funding might soon be done away with as well.

In my Order, this liability insurance limit stipulation was to be for three years. As it stands, just over half of that time has been actively served even though it has been more than five years since the original decree. The remaining time (over two separate work gaps) has been spent unemployed, unemployable and penniless as a result of this malpractice coverage limit issue. With mounting professional obligations, I am once more staring at the reality of being back in this jobless state. Please consider the following. When combining a strong clinical performance history in all other areas of my specialty throughout my career along with the type of forceps deliveries at the heart of the Determination having been eliminated from my practice (while also being a nonfactor in being able to safely care for patients), coupled with the fact that all of my time thus far served under the Order has been done so with a practice monitor closely examining my patient care with no deficiencies found, there is really little to no added liability to my practice then, above and beyond what it always has been such that I should continue to have this portion of the Order imposed. Knowing the center of the Board's focus is protecting the public's interest, the public is not nor does the record show (a complication rate thirty times lower than the national average) that it has ever been at increased danger by my practice of medicine. Therefore, given all that has been presented in this section, new evidence exists along with circumstances subsequent to the Order such that a reconsideration of the measure of discipline is warranted. Thus, I urge you to modify my Board Order as "time served" on the previous limits and mandate that I maintain 1.3M/3.9M coverage, which is still above the minimum. This will open up a whole world of potential companies and ease the greatest of financial burdens while still providing an enhanced level of coverage. It is asked that this request receive utmost priority given current renewal time frames that I presently find myself in. Understanding that the law states that this insurance mandate must be imposed upon a monitored licensee, it is therefore necessary to address this portion of the Order, which is as follows.

Practice Monitor Requirement

The third probationary requirement that was imposed on my license in 2008 is that of a practice monitor. I have previously written both the Board as well as my Monitoring Program Official about the difficulties encountered with this one particular component. For both personal reasons (five children) and professional constraints, I have chosen to remain in my longstanding medical community in order to practice, much to my chagrin. Accordingly, after an experience such as this, it was extremely difficult to satisfy this monitor requirement. Literally no one would agree to do it out of literal fear of reprisal from the very same element that befell me. Thus, having this one condition in place puts an exceedingly tight limit on my ability to practice within the State itself. For example, if there was ever a desire to relocate, it makes it almost impossible to do. People are so disinclined to helping others, not to mention a stranger, (even at the physician level), that they would scarcely step up and assist in this monitor capacity. Further, no practice or hospital is going to want to employ anyone with such a condition attached. I know this from first hand experience after being rejected by over thirty different employment opportunities –

some of whom were/are desperate for a physician in my specialty. Even if I desired to do some locum tenens (part-time/fill-in) work somewhere in the State, I am certain to be automatically disqualified due to this practice monitor requirement alone, not to mention that very license limitation that the recruiters *even* recognize as having no real bearing on capacity to practice fully but yet adds to the disqualification criteria nonetheless. It all boils down to the stigma perceived by others and the label that generates it. If present, then it spells automatic ineligibility – no questions asked.

You stated in your previous letter concerning this matter that my inability to obtain a practice monitor was not a criterion for reconsideration of this component of the Order. This is not the same as not wanting to have a practice monitor. Here you have a physician dutifully seeking out his colleagues in an effort to satisfy this condition only to be turned away by everyone. This community has been professionally polluted to the point that no one will help. Yet I am stuck here since (as mentioned) there is little chance of finding anyone elsewhere in the State to step up either, should I even think about moving. Given that my actual experience has been one of not being able to secure anyone to fulfill this role, either locally and more importantly, in some other potential community, it would appear that this alone would be enough for the Board to reconsider some element of this requirement since it has been integral in not being able to work. This is why I tried to come up with some alternative form of monitoring in my last letter. Unless the Department of Health's objective was for me to never work again in New York State, then it would seem only prudent for my petition on this area to also receive due contemplation as new material evidence as well as new circumstances that would warrant reconsideration.

I understand the clinical matters you cited in your letter as the basis for why the ARB imposed these monitoring terms. But please also recognize again that the issues were over the perceived application of written standards where the outcomes were all good. And I already addressed the issue of using forceps during my hospital "suspension with supervision" time frame back in 2001. In fact, this issue was not even one of the listed charges for the hearings yet received a lopsided amount of weight in the determination without even a basis. Nonetheless, all this aside, the concerns for why the ARB imposed a practice monitor are essentially made moot by the forceps restriction itself, since my actions here were the reasons you cited in your letter as to why they did so in the first place. You also stated that my time off was an additional reason for why a monitor should be in place even though this was never stated in the Order as a reason to consider. That said, after having been off work for more than two years, this past year alone has demonstrated that more than a decade of extensive practice experience and applied knowledge does not evaporate overnight even though there may be a substantial layoff. The other question that begs to be asked is the following. For even the greatest of hypothetical doctors, how much time back in practice is enough to reliably erase any concern after he has been out of work for two years. I dare say that three months would seem sufficient with six months being more than adequate. In my case, it has been more than a year back in practice and my skills and knowledge have never been keener.

You also mention that I was once able to secure a monitor at the outset. Well, it was not the "outset" in the truest sense but was, in fact, thirteen months after the Order was imposed. This was because, in addition to the other components listed above, I had a hard time finding even this gentleman to serve as my monitor. He agreed and ultimately provided two quarterly reports to the State. It must be said, however, that these duties were done by him under a cloud of duress given his official position within the adversarial hospital where this all began as well as his ties to the Ob/Gyn community. And despite him not "quitting" as my monitor as far as I know, when asked to resume his role, he repeatedly refused citing a new reason each time. In fact, in order to abrogate one's duties as a monitor, it must be done so in writing to the State along with

notification of the other parties as well. I know I never wrote anything severing this monitor relationship. Whether he wrote anything essentially relinquishing his duties (i.e., quitting), I am not certain. Therefore, despite what you might perceive as being readily able to secure this component of the Order, truthfully, it was the one portion that I was the most concerned about ever being able to satisfy. Sure, I suspect that the majority of physicians under a practice monitor Order have numerous colleagues that they could turn to for this need and have it gladly fulfilled. The difference in my case is that I was an outsider to this town who was in solo private practice. Sure I made some friends. However, the indigenous element that was central to my travails is a real and feared entity that has shown no discrimination in the past. Therefore, those willing to help were non-existent. If one would agree, within a week, there would be a sudden change of heart. But for the only man possible in this entire community to actually fulfill this role stepping up, I would still be out of work. And when I say "only", this is no understatement. He was my last hope and fortunately, we knew each other from medical school on top of what he witnessed happen to my career. We hadn't spoke in years, yet when I asked, he agreed. It wasn't long before he was hounded as to his decision. Still, he has remained steadfast. He just so happens to be considered one of the area's premier physicians in my specialty who also carries a great deal of influence such that he would be safe from any hostile response or retaliation. It all sounds dramatic and unfortunately, it is. This is the nature of this community. Save for my current monitor, there is nary a person elsewhere in this State that would reliably fill this role such that I could even contemplate leaving the very region that appears to have, in a sense, enslaved me.

Further in my defense are the following two points as well. First, as previously stated, my entire body of work and clinical history demonstrably bears out the fact that I practice sound, safe and successful medicine both in the office as well as the hospital. The ruling in my Order had nothing to do with objective issues or outcome, but involved the more subjective "physician judgment" contention for cases that are otherwise rarely encountered. Secondly, for a total of eighteen months across two different practice monitors, all of my work has been closely examined, written up and received approval. And this is with a very meticulous present day monitor who spends countless hours going through my charts in detail. Naturally, there have been some excellent clinical discussions and points made amongst two colleagues in the context of these reviews. Yet, there has been no example of a single significant misstep in patient management during this time. It stands to reason that with eighteen plus months of close scrutiny without a deficiency, combined with more than ten years of similar performance from the same practitioner, that the Board can extrapolate the obvious and be safely satisfied that I am consistently and customarily adhering to the standards of care as set forth by my specialty such that I do not represent any sort of danger to the community and thus a monitor is no longer needed. That my time has been served, especially when considering the totality of what has been presented here. Therefore, as a third component of this letter, it is with this new evidence and these circumstances I urge the Board to reconsider the terms and modify the Order so that the requirement of Practice Monitor would be deemed satisfied.

Time Served and Relative Applicability

Never being that good at writing a letter such as this when the issues are so critical to the writer, I struggle with just what to say in order to summon consideration. For lack of a better description, this section is simply to address the enormous losses and the length of time I have had taken from me, my family, my career, my patients, my staff, my friends, my church, my life as a result of this matter with the DOH. This has been a non-stop almost twelve year encounter. With all the official writing and paperwork alone, this letter cannot begin to describe what it was like to worryingly live through those thousands of hours over multiple years. Somewhere along the line, I hope the Board hasn't forgotten how many years of hard work it took to reach that

point of career success where it was all in jeopardy over these matters such that I was compelled to defend myself as I did. As a result of this entire experience, I did in fact lose it all. This would include a highly successful practice, a home, a marriage, day-to-day access to my five children, a standup reputation, you name it. While it apparently goes with the territory on a personal level, on a professional one, all I am trying to do is get by. It is contended through this writing that the personal and professional losses combined with the nearly twelve years of constant involvement with this matter has been time enough served, especially when all indicators are that I am no threat to the community. For the State, it was officially over more than five years ago with the three year probationary terms already two plus years past their original expiration date due to the continued undermining effects they have had on being able to practice.

Since my original Order came down in April of 2008, I have only worked eighteen out of those 62 months, all because of the logistical impediments that have been created by my present Board Order. And even though I was finally able to get past those hurdles just enough to get the office reopened in 2012, the continued burden brought on by the Order has resulted in a gross adjusted income last year in excess of -$55K. That is a negative number, just to be clear. In excess means that it was even lower than that number. In essence, even though I am working full time, I have been relegated to living like a pauper on a nominal benevolent fund for troubled physicians as my only means of survival. Given the massive debt and professional commitments still in place, the only way I can possibly overcome is to work as a physician.

Twenty years out from medical school, I should not be in this position. I didn't deserve all of this. After adjudicating this matter with the State for nearly six years, no one getting hurt, no malpractice involved, catastrophic losses experienced on my part, sound and solid argument offered in this letter addressing the three issues that continue to plague my practice of medicine, five children, a respectable practice history, plenty of time served, I urge the Board to have mercy on this situation. I need help. I need your help. I have contemplated writing to all sorts of State officials seeking some sort of endorsement on this matter. As you know, I even wrote the governor's office on more than one occasion. This is not to be inflammatory by any means. It is merely out of desperation that this plea fall on the desk of someone who actually cares. I do hope you do, especially given the power granted to you. Since time is somewhat important, it is asked that this matter be dutifully considered and the authority of the Board favorably applied in this matter. Thank you.

Respectfully,

James R. Caputo, M.D.

c.c. Diane K. Riley