NEW YORK STATE DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER

OF

DANIELLE ROBERTS, D.O.

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RESPONDENT'S MEMORANDUM TO THE HEARING COMMITTEE

Preliminary Statement

Respondent, Danielle Roberts, D.O., submits this Memorandum to the Hearing Committee in support of her position that the charges against her constitute an improper attempt by the Office of Professional Medical Conduct ("OPMC") to exercise jurisdiction over the purely private, non-medical conduct of a physician in violation of the New York Education Law and the New York Public Health Law. This effort is not only dangerous for physicians but also is a gross misuse of resources as it places the State Board for Professional Medical Conduct in a position where it is being called upon to utilize its limited resources to pursue a purely political attack on perfectly legal and private activities. Moreover, the Courts have made it clear that the State Board, like all administrative agencies, is a creature of statute and, as such, has only the jurisdiction granted to it by the Legislature. *New York State Association of Nurse Anesthetists v. Novello, 189 Misc. 2d 564 (Sup. Ct. Albany Co. 2001) aff'd 301 AD2d 895 rev. on other grounds*

2 NY 3d 2007 (2004). The jurisdiction granted to the Board does not extend to the regulation of physicians in their private lives and to activities not considered the practice of medicine. As we show below, the evidence adduced at the hearing demonstrates that branding is not a medical procedure and that Dr. Roberts was not engaged in the practice of medicine when she gave a brand to several women who sought out and consented to this activity for their own reasons.

STATEMENT OF THE CASE

In an Amended Statement of Charges, OPMC asserted that Dr. Roberts committed professional misconduct by giving a brand to a number of women identified in the charges. (Exhibit 1) (Citations herein are to exhibits in evidence and to pages in the transcript.) The women are referred to in the charges as “Patients A-G”. We decline to refer to the women who received a brand as “patients” because the evidence was quite clear, indeed overwhelming, that none of the women were patients of Dr. Roberts and did not see Dr. Roberts in her capacity as a physician.

OPMC was quite aware of this fundamental defect and fatal flaw in the legal validity of its charges. That is why the branding procedure is delineated as a “medical procedure” 55 times in the Amended Statement of Charges. Apparently, OPMC hopes that if you repeat a falsehood often enough, people (such as a Hearing Committee) will begin to believe it, a tactic sometimes employed by politicians. A review of the relevant provision of the New York Education Law, however, makes it indisputable that the branding performed by Dr. Roberts was not a medical procedure. Section 6521 of the Education Law is entitled “Definition of Practice of Medicine”

and provides that "The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition." There can be no doubt that this provision is applicable. A number of years ago, OPMC charged Elliot Gross, MD, with professional misconduct relating to several autopsies that he performed in the course of his position and professional duties as the Chief Medical Examiner for New York City. During the administrative proceeding before the State Board for Professional Medical Conduct a motion was made to dismiss the charges as lacking in jurisdiction. The argument in favor of dismissal was that forensic autopsies, which involve cadavers rather than live patients, do not fall within Section 6521 of the Education Law and thus are not the practice of medicine. This legal issue ultimately worked its way to the courts and the Appellate Division held that the State Board did have jurisdiction to hear and decide the charges against Dr. Gross but the Court's reasoning is especially pertinent to Dr. Roberts' case. The Court recognized the applicability of Education Law Section 6521 but noted that an autopsy is the "ultimate diagnosis" and, as such, falls within the statutory definition of medical practice. *Matter of Gross v. Ambach, 126 A.D. 2d 21 (Third Dept. 1987) aff'd 71 N.Y.2d 859 (1988*). Thus, it is clear that Section 6521 must be considered in the determination as to whether branding is a medical procedure that is within the practice of medicine as defined by the New York Education Law. Accordingly, an analysis of Section 6521 and the pertinent facts is in order. Section 6521 contains a two-pronged test. First, the activity must involve "diagnosing, treating, operating or prescribing." While branding does not involve diagnosing, treating or prescribing, it arguably involves "operating." But this is only the first prong of the test. The "operating" must be for a human disease, pain, injury, deformity or physical condition. It should be blatantly obvious that none of these criteria are implicated.

The women who received a brand were perfectly normal and healthy in all respects and OPMC presented no evidence to the contrary. No evidence was offered by OPMC that the women who received a brand had any "disease, pain, injury, deformity or physical condition." Since this second prong of Section 6521 was not met or satisfied, it is evident that branding is not a medical procedure and does not fall within the statutory definition of the practice of medicine. The fact that branding may have some risks associated with it is utterly irrelevant. Many procedures and activities people choose to engage in on a regular basis carry associated risks (electrolysis, massage, fitness and yoga classes) but they are not considered medical practice just because a physician may administer or lead them.

To further illuminate the distinction between activities and contexts that carry risk with them but are outside the context of medical practice and the jurisdiction of the State Board, consider: there are many processes and activities people do every day that have risks associated but are not considered the practice of medicine – some even arguably closer to "treating a condition" than giving a brand could ever be. Take teaching an aerobics class; because the instructor is a physician would she be required to take a medical history on every person that gets on a spin bike in her aerobics class? Of course not; that would not be appropriate for the activity being engaged in. There are other responsibilities and standards that have been created for aerobics instructors to uphold that are appropriate for this activity and those who choose to participate have a responsibility to check with their physician or determine on their own whether they are fit for this activity. Though this activity could possibly treat a condition (diabetes, heart disease, musculoskeletal imbalances), it is not considered the practice of medicine and a physician who leads the activity would not be expected to treat it like a medical practice just

because he or she has a medical license. The physician would be expected to adhere to the standards associated with the activity – not the more rigorous standards of medical practice.

Branding is no exception. It is an unregulated activity which people choose to engage in at their local tattoo shop, fraternity, sorority or home. The branding technician/artist and the participant have responsibilities to keep each other safe during the process, and there are accepted standards and practices that apply – but these are not medical standards; they are branding standards. That the branding technician/artist is a physician does not alter the applicable standards.

The fact that branding is not a medical procedure under the applicable law and relevant facts, does not, however, automatically preclude the Board's jurisdiction. If this activity was performed in the course of Dr. Roberts' medical practice or it otherwise implicated her medical license, the Board could still reasonably exercise jurisdiction. For example, if a gynecologist performing a pelvic examination sexually touches a patient purely for his sexual gratification, everyone would agree that this conduct (the improper touching) would not be considered a medical practice or procedure. But everyone would also agree that the conduct represents "conduct in the practice of the profession which evidences moral unfitness to practice medicine" in violation of Section 6530 (20) of the Education Law. Thus, for the State Board's jurisdiction to be properly invoked, the conduct must fall within the definition of the practice of medicine (under Education Law Section 6521) or, at least, the conduct must have occurred in the environment and context of medical practice. The same analysis applies to all of OPMC's charges against Dr. Roberts relating to the branding process.

Dr. Roberts was charged with practicing the profession of medicine with gross negligence and gross incompetence and practicing the profession of medicine with negligence

and incompetence on more than one occasion based on the facts and circumstances surrounding the branding process. To establish these charges, OPMC was required to prove that not only was Dr. Roberts grossly negligent, grossly incompetent, and negligent and/or incompetent but also that her conduct occurred in the practice of medicine. She was also charged with engaging in conduct in the practice of medicine which evidences moral unfitness to practice medicine. The law is well-settled that the issue of whether conduct occurs in the practice of medicine is a factual determination to be made by a hearing committee based on all of the pertinent facts. With that in mind, we set forth below how the evidence adduced at the hearing demonstrates that Danielle was engaged in conduct that was clearly outside the practice of medicine and in no way implicated her medical license. Throughout this Memorandum, respondent is sometimes referred to as "Danielle" where the context indicates that she was not performing a medical procedure, was not engaged in the practice of medicine and was not regarded by others as their physician.

First and foremost is the fact that the women receiving a brand did not perceive that Danielle was functioning as a physician when she gave them a brand. Several women who received a brand from Danielle testified on her behalf. Each testified that she did not consider Danielle to be her physician. (1887, 1943, 1950-1951). Similarly, Dr. Roberts testified that she perceived herself to be acting as a branding technician rather than a physician and she did not consider the women to whom she gave brands to be her patients (750, 1337).

The women who received brands and who testified on behalf of Dr. Roberts were Jane Doe 3, Jane Doe 4 and Jane Doe 5. They testified that when they agreed to join DOS they were told that receiving a brand would be part of their initiation ceremony (1881-1882, 1939, 2013-2015). Not one of them testified that they were advised that they would be getting a tattoo rather than a brand. (1882, 1939, 2014-2015). Each of these women testified that when they agreed to

receive a brand they had no idea that a physician would be doing the branding and they were not relying on or contemplating that a physician would be doing the branding (1883, 1939-1940, 1943). The only person who gave slightly different testimony was prosecution witness S.E. According to S.E., she was told that a small tattoo would be required and that she didn't know it would be a brand until much later on - the night the branding took place (793). S.E. further testified that she didn't want to receive a brand but she felt comforted by the fact that it would be done by a physician (796). It seems unlikely that all of the other women who received a brand knew from the outset that a brand would be required and only S.E. was told that it would be a small tattoo. It was apparent from her testimony that S.E. became angry at DOS and everyone involved with DOS including Danielle and was trying her best to incriminate Dr. Roberts. SE is the woman seen receiving a brand on the video in evidence (Exhibit 8C). She was confronted on cross-examination with information that she provided to an OPMC investigator which clearly is inconsistent with what can be plainly seen on the video (884-895). In an apparent effort to "reconcile" her prior statements with the video, S.E. claimed that the OPMC investigator got everything she told him wrong (884-895). A far more likely explanation is that when S.E. realized that what she told the investigator was inconsistent with the video, she had to assert that the investigator's summary was inaccurate. But even if S.E.'s testimony was truthful it still would not establish that a physician/patient relationship existed between her and Danielle on the day she received her brand. It takes more than S.E. stating that she was "comforted" that a physician would be doing the branding to establish a physician/patient relationship. Numerous other factors demonstrate that the branding did not take place in the context of a physician/patient relationship and that Danielle was acting as a branding technician/artist in a private capacity that was not part of medical practice. We set forth below some of these factors.

The branding was performed in a private home rather than in a hospital, medical facility or physician's office (1336-1337, 1886). The branding was not paid for (1338, 1886). No medications were prescribed. No scripts at all were written (1352). None of the formalities normally associated with medical practice were observed. No formal written informed consent was obtained (although verbal consent was documented as can be seen from the video in evidence). No history was taken and no physical examination was performed. No medical records were maintained. No insurance information was obtained. Insurance billing codes for branding don't exist. The women who received a brand did not know who would be performing the branding (1943). The women of DOS who received a brand initially (before Danielle became involved) received their brands from a branding artist (1315, 1323, 2019). When they decided that future branding should be done in a more intimate setting, they considered several possible people to perform the task (2019-2021). Only one of the candidates was a physician – Danielle. Clearly, the intent was not to select a physician but to pick amongst friends (1314).

Danielle agreed to the request that she perform the branding, but only after she received a brand herself and only after she satisfied herself that she could perform this task safely and competently (1322, 1327-1331). It was necessary for her to research the subject and talk to branding artists because branding is not taught in medical school; there are no residencies in branding (1327-1331, 1784) and there was no way to learn about branding through traditional medical avenues. Branding is not a medical practice or procedure; it is a form of commercial body art in the same manner as are tattooing and body piercing. Thus, Danielle's knowledge about branding was not derived from her medical education, training or experience (1784).

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A number of states regulate branding under the rubric of commercial body art. For example, Arkansas, Idaho, Louisiana and Michigan, among many others, regulate branding as a form of commercial body art. It is noteworthy that some of the states that regulate branding distinguish between branding performed for aesthetic or ritual purposes and branding performed incidental to medical practice. See, for example, Michigan Body Art Facilities Act 210 PA 375 Section 3.1.9 which specifically distinguishes branding for aesthetic purposes from branding which the State Board determines to be medical in nature. It is only medical branding that falls within the jurisdiction of the medical board. In New York, it is even more clear that aesthetic or ritual branding is outside the jurisdiction of the State Board for Professional Medical Conduct as branding is not regulated at all in New York. Pursuant to Article 4-A of the New York Public Health Law, tattooing and body piercing (but not branding) are regulated activities that require a license issued by the Department of Health. The only exemption is for physicians. Thus, a physician who performs tattooing or body piercing who does not possess a license issued pursuant to Article 4A necessarily relies upon his or her medical license for the legal authority to perform that activity. But this is not true for branding. Therefore, when a physician performs branding his or her medical license is not implicated because the physician does not need to rely upon a statutory exemption (as would be true for tattooing and body piercing) because branding is not regulated at all.

OPMC attempted to argue that Dr. Roberts was engaged in medical practice when she performed the branding because she used an electrocautery which is a "medical" device sometimes used by physicians in the course of medical practice (1070-1071). But anyone can legally purchase an electrocautery – no medical license is required for such a purchase (1329,

1768). This is unlike an X-ray machine. Such machines can only be purchased by a hospital, medical facility or appropriately licensed person.

Moreover, an electrocautery was purchased by Danielle solely for the purpose of performing the branding that she was asked to do. Steve Haworth testified as a fact/expert witness on behalf of Dr. Roberts. He explained that he was the first person to utilize an electrocautery for the purpose of branding to replace strike branding with hot metal which was commonly used before he brought the electrocautery into vogue (1760-1761). Danielle purchased the same device used by Mr. Haworth (2124). It should thus be clear that Danielle's use of an electrocautery in no way implicated her medical license, medical education, medical training or medical experience and the device was only used for this single, non-medical purpose, i.e. branding.

OPMC's other arguments that Dr. Roberts was engaged in medical practice when she performed the branding (and thus subject to the jurisdiction of the State Board) are equally unavailing. OPMC pointed out that Dr. Roberts utilized bandages; she kept the brands clean; she wore gloves and the "patients" were placed on an "examining" table. All of these and other similar points are common to any branding procedure and in no way transform branding into an aspect of medical practice. OPMC also attempted to prove that Dr. Roberts was engaged in medical practice by offering the expert testimony of Dr. Robert Grant. But the expert testimony provided by Dr. Grant was not persuasive.

Dr. Grant conceded that there are no medical programs that involve branding. (1185). He further admitted that he has no experience whatsoever with branding (1185-11186). The primary argument advanced by Dr. Grant was utterly without merit. He attempted to argue that branding is analogous to cosmetic surgery. It was Dr. Grant's position that cosmetic surgery is universally

recognized as the practice of medicine. From this basic truism, he next argued that cosmetic surgery falls within the definition of the practice of medicine set forth in Section 6521 of the Education Law. He reasoned that cosmetic surgeons treat “psychic pain” that the patient has from having a part of their body that displeases them and results in a type of emotional pain that he labeled “psychic pain” (1191-1192). Since Section 6521 includes the treatment of pain as part of the definition of the practice of medicine, he argued that cosmetic surgery is therefore the practice of medicine. From this, Dr. Grant argued that branding is also medical practice because it too treats a type of psychic pain. He did not make clear, however, the basis for his position that persons receiving a brand are experiencing “psychic pain.” In any event, his argument is so preposterous and without merit that ordinarily we would not even dignify it with a response. But the stakes in this case are too high to leave this absurd argument unchallenged.

Dr. Grant cited no authority whatsoever for his claim that all cosmetic surgery patients, are experiencing what he referred to as “psychic pain.” Moreover, if he really believed that all of his cosmetic surgery patients are being treated for psychic pain, then it would be incumbent on him to arrange for every patient to undergo a psychiatric evaluation before having cosmetic surgery. He provided no such testimony and we seriously doubt that all of his cosmetic surgery patients are required to undergo a psychiatric evaluation before he operates on them. Furthermore, a simple hypothetical should suffice to show the lack of merit to Dr. Grant’s argument.

Hypothesize a successful face model who is extremely happy with her appearance. She nevertheless is advised by her agent that she can earn substantially more money for each photo shoot if she has cosmetic surgery on her nose making it slightly smaller; she agrees to this for the financial reward despite being perfectly content with her appearance and having absolutely no “psychic pain” whatsoever with the way she looks. According to Dr. Grant’s argument, the

cosmetic surgeon who performs the requested procedure would not be practicing medicine since in our hypothetical situation there is no psychic pain being treated. But common-sense dictates that this hypothetical rhinoplasty is clearly the practice of medicine. The reason that it is the practice of medicine is the same reason that all cosmetic surgery is considered the practice of medicine. Cosmetic surgeons operate on or treat a "physical condition" that the patient wants to have addressed. The physical condition could be a nose that the patient wants changed or wrinkles that he or she wants removed or a plethora of other physical conditions. Since treating or operating on a "physical condition" falls within Section 6521, cosmetic surgery constitutes the practice of medicine. While we do not doubt that in some instances patients undergoing cosmetic surgery will obtain some emotional or psychic benefit, this does not mean that this constitutes the basis for deeming cosmetic surgery as the practice of medicine.

Indeed, Dr. Grant's argument is so lacking in a rational basis, that one can only conclude that he was not acting as a non-partisan expert, but rather was creating an argument in an attempt to achieve a desired result – in other words, the end justifies the means. It is also the case that while Dr. Grant is a highly experienced and respected plastic surgeon, neither his testimony nor his *curriculum vitae* demonstrates any legal training or background. This is especially important in this case which did not present clinical issues in plastic surgery but rather involved a somewhat complex application of the facts to the applicable law. The credentials of defense expert David Mayer, M.D., were, however, particularly pertinent to the expert testimony that he provided.

Dr. Mayer graduated from Cornell Medical College (1st in his class). He performed a five-year residency in general surgery at New York Hospital-Weil Cornell Medical Center which he completed in 1978 (1469-1470). He has been certified by the American Board of Surgery

since 1979 (1470). Following his residency, Dr. Mayer practiced as a busy general and vascular surgeon in the Northwell Health System. He served as Chairman of Surgery at Syosset Hospital where he had supervisory responsibility for 250 surgeons including various specialties such as general surgery, plastic surgery, orthopedic surgery, etc., as well as running an advanced laparoscopic, minimally invasive fellowship program (1471). He teaches medical students and residents at New York Medical College, Hofstra Medical School and the State University of New York at Stonybrook (1470-1474). Dr. Mayer has published extensively – over 50 peer reviewed articles and three book chapters in the field of surgery (1971-1972). He has also lectured widely in the United States and internationally (1472). In addition, Dr. Mayer is a licensed attorney having graduated *summa cum laude* from the Hofstra University School of Law in 2010, and he has an expertise in Health Law (1472). Clearly, he brings to his testimony a rather unique dual perspective.

In preparation for his testimony, Dr. Mayer reviewed the relevant hearing transcripts including the testimony of Dr. Grant, Dr. Roberts and S.E. (1972). He also reviewed the video of Danielle performing the branding of S.E., as well as the relevant provision of the New York Education Law (1473). As he testified:

> In my expert opinion and testimony to a reasonable degree of medical certainty, Dr. Roberts was not engaged in the practice of medicine when she performed the branding procedure. In fact, she was acting as a branding tech or a scarification artist rather than a physician or osteopathic physician. (1473)

Dr. Mayer explained that his opinion was based on his training and experience both as a physician and attorney and on the application of the pertinent facts to the applicable law (1474). He emphasized the fact that the women who received brands had no prior knowledge that a

physician would be doing the branding and that therefore the confidential relationship of trust that is crucial to the doctor/patient relationship didn't exist (1475-1476). He disagreed with Dr. Grant's analysis and Dr. Grant's analogy of branding to cosmetic surgery. He explained that cosmetic surgeons treat a patient's perceived physical condition – not "psychic pain" as asserted by Dr. Grant (1480-1481).

OPMC was well aware of the weakness of its argument as to branding being a medical procedure. In an effort to circumvent this fatal flaw in the charges, OPMC attempted to argue that even if the branding itself is not the practice of medicine, the "follow-up" care or alleged lack of such care by Dr. Roberts constituted the practice of medicine, thus subjecting her to the jurisdiction of the State Board. But this argument fails as well.

Although there is always a theoretical risk of harm following the creation of the brand/scar, Danielle did not provide medical follow-up care. The risks from the branding process are exceedingly small and the women were told to follow-up with their own physician if any medical issues arose (418-419, 436-437, 1352, 1370). OPMC argued through the testimony of its expert, Dr. Grant, that Dr. Roberts acted irresponsibly and negligently because she created a second degree burn with the electrocautery which required medical attention which she did not provide. But branding expert, Steve Haworth, explained that the electrocautery doesn't cause a true second degree burn because it only vaporizes the layers of skin it directly touches and leaves intact the surrounding cells and blood supply, thus being categorized as a second degree burn only because it removes two layers of skin (1787-1789). However, the wound it creates carries significantly less infection risk and heals much more quickly than typical second degree burns caused by scalding water or by strike branding with a hot iron (1787-1789); – which medical professionals typically encounter and are trained to manage. The exaggeration of the "risks"

associated with electrocautery branding was compounded by OPMC's placing in evidence (over objection) of numerous photos of the branding scar in the healing process (Exhibit 47). The photos of the brands offered by OPMC were significantly enlarged, backlighted and reddened to create the impression that the scar that was created was extensive and constituted a significant risk to the women who received the brands (1357-1358).

The only post-branding instructions that Danielle gave related to the aesthetics of the brand (668, 1349-1350, 1979). Obviously, she advised the women to keep the scar clean with a clear plastic bandage (534-535, 1349-1350), but this was no more than any branding technician/artist does. Dr. Mayer pointed out that there are many personal services such as tattooing, piercing, waxing, facials, electrolysis, perms and eyelash extensions where it is well-settled that they are not the practice of medicine. He explained that it is routine for those providing such services to give aftercare instructions that are considered general care rather than medical in nature (1483). He testified that the fact that Dr. Roberts provided routine instructions for aesthetic purposes was not an indicia of medical practice (1483). The women who received the brand all understood that they should follow-up with their primary care doctor or go to an emergency room should any complications develop (1352, 1370, 1893). This was understood because they were all aware that Danielle was not functioning as their physician (1943, 1959). The only exception to this was the testimony of prosecution witness S.E. But it was obvious that S.E. provided false, biased testimony. This can be seen from her earlier text messages to Dr. Roberts where she referred to Dr. Roberts as "Danielle." (669). Later, when she was trying to incriminate Danielle, her texts sought "medical" advice and referred to Danielle as "Dr. Roberts." (Exhibit 35; 669).

It should be noted that we are not making the argument that merely because unlicensed persons can legally perform a task that it cannot be the practice of medicine. This is a "straw

man” argument raised by OPMC in its oral closing. By way of illustration, the definition of the licensed profession of public accountancy does not include the preparation of tax returns. See, Education Law Section 7401. This permits companies such as H&R Block to prepare tax returns without employing CPAs. Yet it is common knowledge that many people elect to use a CPA for the preparation of their tax returns. When a CPA incorporates the preparation of tax returns into his or her accounting practice and clients go to the CPA for that purpose, it is clear that the CPA is subject to the jurisdiction of the State Board for Public Accountancy if he or she were to act fraudulently, negligently or immorally. It would not be a valid jurisdictional defense that anyone, including unlicensed persons, can legally prepare a tax return. But that is very different from the situation involved in this case. In the former case, the preparation of tax returns is incorporated into the CPA’s accounting practice and the clients who seek out that service do so precisely because they want a CPA to take responsibility for their tax returns. It would thus be incorrect to assert that a CPA who acts unprofessionally with respect to the preparation of tax returns can do so with impunity because he or she is not engaged in the practice of his or her profession. And we make no such argument here. We do not argue that because anyone can perform branding that, therefore, Danielle was not engaged in the practice of medicine.

Danielle was not engaged in the practice of medicine for the reasons referred to above. She did not incorporate branding into her general practice of medicine and the women did not come to her because she was a physician and they all had agreed to the branding before even knowing that DOS had recruited her to perform the branding. Thus, OPMC’s strawman argument fails.

OPMC’s remaining arguments (and charges) also have no merit. OPMC alleged that Dr. Roberts committed professional misconduct because she “failed to meet the accepted standards

of medical practice related to the “medical procedure” that she performed. Thus, OPMC alleged that Dr. Roberts practiced medicine negligently and incompetently because she did not take a medical history and did not perform a physical examination prior to giving the women the brands that they requested; she did not obtain a formal written consent and she did not offer the women anesthesia to mitigate or eliminate the pain associated with the branding. Finally, OPMC alleged that Dr. Roberts failed to maintain a medical record reflecting her evaluation and treatment of the women who received the brands. Paradoxically, that Danielle didn’t do these things is actually consistent with her not being engaged in the practice of medicine. As Dr. Mayer testified “the things that she didn’t do are understandably disturbing to OPMC when OPMC reviews a case. But, in this case, they support the proposition that she did not engage in the practice of medicine, and therefore, wouldn’t need to do the indicia of medical practices and documentations that medical practice would normally require.” (1483-1484). Although Dr. Grant testified that Dr. Roberts deviated from the accepted standards of practice by not performing a history and physical and by not obtaining informed consent, etc., he admitted on cross-examination that his testimony was premised on the idea that Dr. Roberts was engaging in medical practice when she performed the branding and that this triggered the standards of medical practice that she was obligated to comply with (1198-1199). Inconsistently and even bizarrely, Dr. Grant insisted that these medical standards would still apply even if the Hearing Committee were to conclude that branding is not a medical procedure; that the women who were branded were not patients of Dr. Roberts; and that Dr. Roberts was not engaged in the practice of medicine (1199).

Of particular concern to OPMC was the fact that Dr. Roberts had no “medical justification” for not offering anesthesia to the women who received the brands to eliminate or

mitigate the pain associated with the branding. But this concern misperceives the purpose of the branding and the concept of the shared experience that was intended to create a bond among the women that they had all persevered through a difficult and painful experience (411-412, 748, 1325-1326, 2023-2025). Even prosecution witness S.E. conceded this. Several witnesses testified that receiving anesthesia during the branding process would have defeated one of the primary purposes of the branding (411-412, 1325-1326, 1888, 1947-1948, 2023-2025).

There was testimony during the hearing about the African American fraternity known as the Omegas and that many prominent African-Americans including former basketball player, Michael Jordan, are members of this prestigious college fraternity (415, 663, 748, 753). Many of the Omegas choose to be branded with the Greek letters symbolizing their life-long membership in the fraternity. The brand is accomplished by the use of a hot iron on the exposed flesh. Presumably, this is quite painful. Imagine if it were ascertained that one of the Omegas so branded was given anesthesia to eliminate the pain. That fraternity brother would not have the respect of those who endured the branding and accepted the pain as a symbol of their commitment. Instead of being a bonding experience, it would be divisive. The branding experience involving the DOS women was similar. It was intended to be a shared bonding experience, not a shared medical experience. The idea was not merely to obtain the final result of having a brand but also to persevere through the difficult branding process (411-412, 748, 1325-1326, 2023-2025). The way the women saw themselves can be gleaned from Shakespeare's *Henry V*, Act 4 Scene 3. Before the vastly outnumbered English fight the French at Agincourt in 1415, King Henry addresses his troops:

> We few, we happy few, we band of brothers;
> For he to-day that sheds his blood with me shall be my brother;
> Be he ne'er so vile, this day shall gentle his conditions:
> And gentlemen in England now a-bed shall think themselves accursed
> They were not here, and hold their manhoods cheap whiles any speaks
> That fought with us Saint Crispin's day.

This is the bond that the branded DOS women desired to emulate. They viewed their membership in a secret society as empowering and a show of strength and commitment. They wanted to be a "band of sisters." That bond would be defeated if they were offered anesthesia and some accepted. By regarding the branding as a medical procedure and part of medical practice, Dr. Grant not only failed to correctly interpret Section 6521 of the Education Law, he also failed to understand the initiation bonding ritual that the DOS women wanted and accepted.

OPMC also spent a substantial amount of time delving into the "collateral" provided by the women who were branded. OPMC argued that this constituted coercion and that accordingly, the women were not able to and did not give true consent to the branding. This is blatantly untrue, (as Danielle herself went through the very same process all the women who chose to join DOS went through) and many women testified to the absurdity of this assertion. Moreover, OPMC again fails to understand the illogic of its position. Consent in this forum is only an issue if Danielle was performing a medical procedure and/or was engaged in the practice of medicine. Since it has been shown by clear and convincing evidence that branding is not a medical procedure and that Danielle was not engaged in the practice of medicine, there is no issue of consent that can legally be heard in the misconduct forum. Certainly, whether the DOS women who were branded gave their consent or were coerced is extremely important. This issue, however, would have been adjudicated elsewhere if true. But the fact is there was no coercion as Danielle and several other witnesses testified (530, 1265-1266, 1397, 1925-1929). If there was

coercion, it might constitute immoral conduct, but it would not be "conduct in the practice of medicine which evidences moral unfitness to practice medicine." – the requirement of Section 6530 (20) of the Education Law. The Hearing Committee should take note of the fact that New York only regulates the moral conduct of physicians when they are engaged in the practice of their profession. This is not true for all States. Some States regulate and sanction any conduct by a physician perceived to be immoral. New York has chosen not to follow those States. Indeed, almost all of New York Education Law Section 6530, where misconduct is defined, is limited to acts committed in the course of practicing the profession. The only exceptions are for criminal convictions and drug and alcohol dependency. See, Education Law Sections 6530 (8) and 6530 (9).

By referring to and citing this fact, we do not mean to imply that Danielle engaged in immoral behavior in any way. Rather, this is a response to OPMC's effort to taint Dr. Roberts by improper allegations of guilt by association. That is why counsel for OPMC repeatedly referred to NXIVM, Keith Raniere and DOS. He claimed that this was for the purpose of context. In reality, OPMC's purpose was an attempt to tarnish Dr. Roberts in the eyes of the Hearing Committee based on her purely private, non-medical conduct. As we have shown, Danielle's conduct was, at all times, moral and compassionate. But regardless, it is only her conduct while practicing her profession that is within the purview and jurisdiction of the State Board.

It is critical for the Hearing Committee to understand that Dr. Roberts is a highly moral person and did not engage in immoral conduct in the practice of medicine or outside the practice of medicine. Witnesses testified to her exemplary character. She was described as "exceptionally honest," "caring, compassionate" and "loyal, faithful and full of integrity" (1852, 1863, 1866). We urge the Hearing Committee to review the video in evidence (Exhibit 8C). It can readily be

seen that Danielle was supportive and compassionate. The women were laughing and joking as they shared the experience. There was absolutely nothing resembling coercion or immorality. The Hearing Committee should also consider Dr. Roberts' demeanor as she was testifying. By carefully declining to answer specific questions that did not pertain to the charges but only sought information about her private life, she stood for the right of physicians to have private lives outside of their agreed upon professional commitments, and revealed where those rights were being violated to serve a political agenda. She upheld the honorable foundation and principles the Board was founded on. She stood to safeguard the privacy of non-relevant parties and the sanctity of the commitments she gave when she joined DOS. She did this even when declining to answer might have placed her in legal peril depending on the rulings made by ALJ MacKillop-Soller. This was courageous and benefits us all.

The Charges Relating to "Vanguard" Week

Dr. Roberts was also charged with practicing the profession of medicine with negligence and incompetence because she didn't report the outbreak of a norovirus while on vacation at a corporate retreat in Upstate New York. And she was charged with willfully failing to file a report required by law (Education Law Section 6530 (21)) and willfully (or grossly negligently) failing to comply with a substantial provision of Health Department regulation 10 NYCRR Section 2.1 et. seq. – a regulation mandating that physicians report certain infectious disease situations to the Department of Health. See, Education Law Sectio 6530 (16). We address first the alleged reporting requirement of 10 NYCRR Section 2.1.

Section 2.1 does not require the filing of a report as asserted by OPMC. This regulation, which most physicians are not familiar with, is concerned primarily with "communicable"

diseases. But it is clear from Section 2.1 that the term "communicable disease" is not used in its usual sense and is limited to those diseases specified in Section 2.1. The evidence adduced at the hearing showed that the disease entity that occurred during "Vanguard" week attended by Dr. Roberts and others in 2016 was a norovirus or something very similar thereto (1000). Noroviruses are not included on the list of communicable diseases in Section 2.1 (1300). As such, there was no mandatory reporting requirement. OPMC correctly points out that Section 2.1 also requires the reporting of "unusual" diseases. The evidence was clear, however, that the disease that occurred during Vanguard week 2016 was not "unusual" (1015-1016, 1302). In fact, OPMC's expert conceded that it was a very common, self-limiting disease that was unpleasant but not lethal (1001-1002). It was a garden variety stomach virus, sometimes referred to informally as a stomach bug or 24-hour virus (720). Clearly, this virus was not reportable as an "unusual" disease. *A priori* it was not reportable as an unusual disease outbreak. Next, OPMC asserted that the norovirus had to be reported as a disease outbreak under Section 2.1(c). This subsection states that "any disease outbreak or unusual disease shall also be reported to the State Department of Health as provided in subdivision (b) of the section." But subdivision (b) refers, in turn, to Section 2.10. Title 10 NYCRR Section 2.10 states:

> It shall be the duty of every physician to report to the city, county or district health officer, within whose jurisdiction such patient resides, the full name, age and address of every person with a suspected or confirmed case of a communicable disease, any outbreak of communicable disease, any unusual disease or unusual disease outbreak and as otherwise authorized in section 2.1 of this Part, together with the name of the disease if known, and any additional information requested by the health officer….

Two things are clear from the above quoted language – first, Section 2.10 refers to reporting about "patients," not persons who are known to the physician only as fellow vacationers. This makes Section 2.1 inapplicable to what occurred during Vanguard week. Second, Section 2.10 refers to "communicable diseases, outbreaks of communicable diseases, unusual diseases and unusual disease outbreaks – none of which occurred during Vanguard week if the definitions contained in Section 2.1 are applied as they must be. Apparently, OPMC is attempting to hang its hat on the language in Section 2.10 that refers to "as otherwise authorized in section 2.1 of this Part." But a review of Section 2.1 reveals that there are no other reports mandated or authorized. As can be seen from the foregoing, Dr. Roberts did not violate 10 NYCRR Section 2.1 et. seq. As can also be seen, this regulation is difficult to parse and requires jumping from subdivision to subdivision and the application of technical definitions. This is a challenging task even for lawyers trained in statutory and regulatory interpretation. Even if the Hearing Committee were to disagree with the analysis and interpretation set forth above, the evidence in this case did not demonstrate a "willful" failure to file a report required by law and, just as clearly, the evidence did not establish that Dr. Roberts "willfully or grossly negligently" failed to comply with Title 10 NYCRR Section 2.1 et. seq.

Nor is there any merit to OPMC's charges that, irrespective of Section 2.1 of Title 10, Dr. Roberts practiced the profession of medicine negligently and incompetently by not notifying the Department of Health about the norovirus that occurred during Vanguard week. In an effort to prove that Dr. Roberts departed from accepted standards of practice by not reporting the cases of norovirus (or similar disease) that occurred, OPMC offered the testimony of Dr. Bruce Farber. While we do not question Dr. Farber's credentials as an infectious disease expert, his testimony fell well short of establishing a departure by Dr. Roberts from accepted standards of practice. In

fact, Dr. Farber's testimony established the opposite – that there was no departure from accepted standards by Dr. Roberts.

Dr. Farber testified on direct examination that the disease entity that occurred during Vanguard week was probably a norovirus (1000). On cross-examination, he acknowledged that a norovirus is not an unusual virus and that it is a self-limiting virus which, in most cases, resolves in two or three days (1001-1002). He also admitted that the symptoms, while unpleasant, are rarely lethal (1002). Dr. Farber testified that every New York physician is required to take an infection control course every four years and that he co-authored one such course (1004-1005). Implied in this testimony is that his course and courses like it inform physicians of their reporting obligations and define standard practice in this area. But Dr. Farber admitted that the course he co-authored says nothing about a physician's reporting obligations while on vacation. Curiously, OPMC did not offer in evidence the documents pertaining to the infection control course co-authored by Dr. Farber (1005). The Hearing Committee can be confident that if the infection control course co-authored by Dr. Farber contained any language supporting OPMC's position, the course documents would have been offered in evidence. OPMC, did, however, offer the documents pertaining to an infection control course given at St. Peter's Hospital (1005). That course and the documents related thereto do not refer to any obligation to report a disease such as a norovirus, especially while on vacation and where the disease does not relate to any of a physician's own patients. Moreover, Dr. Farber was unable to identify any textbook that refers to a physician's reporting obligations while on vacation. Nor could he identify any teaching that takes place during a physician's post-graduate training years or scholarly literature that refers to and defines a physician's obligations under such circumstances (1006-1008). His "explanation" was that he hadn't done a literature search in preparation for his testimony (1009). His position

that standard accepted practice requires the reporting of an outbreak of a relatively benign disease such as a norovirus in non-patients while on vacation was completely undermined through questioning by Dr. Raju of the Hearing Committee. Dr. Raju asked Dr. Farber whether in his 40 years of practice he had ever heard of a family practice physician attending a community event reporting an incident such as occurred at Vanguard week (1043-1044). Dr. Farber candidly admitted that he could not recall a single such instance (1044). Given this testimony, it should be clear that there was no valid expert testimony supporting OPMC's negligence and incompetence charges.

CONCLUSION

This case was brought improperly from the outset. OPMC's "case" against Dr. Roberts constitutes a misuse of government resources to prosecute the purely private behavior of a physician. New York's misconduct definitions, which are found in Section 6530 of the Education Law, limit actionable misconduct to conduct that occurs in the practice of medicine. Thus, the Education Law refers to "practicing the profession" with negligence or incompetence (Sections 6530 (2) and (5)) and "conduct in the practice of medicine" which evidences moral unfitness to practice medicine (Section 6530 (20)). One can't help but think that OPMC prosecuted Dr. Roberts because of her connection to an organization that was and is politically unpopular – in other words, guilt by association. This is contrary to everything this country stands for. This case also represents an abuse of the State Board. We believe that members of the Board did not volunteer their time to police the private behavior of their colleagues resulting in no harm. Furthermore, allowing or legitimizing charges like the ones brought against Dr.

Roberts, would condone the government's peering into the private lives of physicians – a scary proposition indeed.

Dr. Roberts has had her career destroyed despite the fact that not a single allegation has been made by an actual patient or colleague against her clinical abilities or integrity as a physician. In fact, during her testimony, she declined to identify the non-medical field in which she is now working for fear that OPMC would further destroy her ability to make a living. Despite tremendous social, legal and financial obstacles, Dr. Roberts has continued to stand for our rights, find other ways to make a living for herself and those she cares for, start new businesses that will help keep people healthy in the face of COVID, and even pursue ways to volunteer her skills during this critical time that we face. She is an unrelenting force for good. The Hearing Committee can and should end this ordeal and allow Dr. Roberts to return to what she earned with years of study and work and what she loves most, the practice of medicine.

Respectfully submitted

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