STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

February 17, 2009

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Sheldon Wieder, M.D.

Redacted Address

Paul Stein, Esq.
NYS Department of Health
90 Church Street – 4th Floor
New York, New York 10007

Daniel J. Hurteu, Esq.
Nixon, Peabody, LLP
Omni Plaza
30 South Pearl Street
Albany, New York 12207-3425

RE: In the Matter of Sheldon Lewis Wieder, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 08-151) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR PROFESSIONAL MEDICAL CONDUCT

In the Matter of	
Sheldon Lewis Wieder, M.D. (Respondent)	Administrative Review Board (ARB)
A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)	Determination and Order No. 08-151

COPY

Before ARB Members Lynch, Pellman, Wagle and Wilson[1]
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): Paul Stein, Esq.
For the Respondent: Daniel J. Hurteau, Esq.

After a hearing below, a BPMC Committee determined that the Respondent, a radiologist, committed professional misconduct and the Committee voted to suspend the Respondent's license to practice medicine in New York State (License), to stay the suspension, to order that the Respondent undergo retraining and to place the Respondent on probation. In this proceeding pursuant to New York Public Health Law (PHL) § 230-c (4)(a)(McKinney 2009), both parties ask the ARB to nullify or modify the Committee's Determination. After reviewing the record below and the parties' review submissions, the ARB votes to affirm the Committee's Determination on the charges and to affirm the Committee's Order for a stayed suspension, with retraining and probation.

[1] ARB Member Richard Milone, M.D. did not take part in this case. The ARB proceeded to consider the case with a four-member quorum, Matter of Wolkoff v. Chassin, 89 N.Y.2d 250 (1996).

Committee Determination on the Charges

The Committee considered charges that the Respondent violated New York Education Law (EL) §§ 6530(3-5) (McKinney 2009) by committing professional misconduct under the following specifications:

- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence, and,
- practicing medicine with incompetence on more than one occasion.

The charges related to the Respondent's interpretation on CT scans for six persons, Patients A - F. The Respondent performed the interpretations as an attending physician at New York University Medical Center (NYU). The record refers to the Patients by initials to protect patient privacy. Following a hearing on the charges, the Committee rendered the Determination now on review.

The Committee determined that the Respondent deviated from medically accepted care standards in the interpretation of a CT scan for Patient A, by missing a mass in the Patient's right kidney. The mass was likely a renal cell carcinoma. A resident on duty at the time of the interpretation, Priya Bhandarker, M.D., notified the Respondent that a study revealed a worrisome mass. As to Patient B, the Committee determined that the Respondent deviated from medically accepted care standards in failing to report ascetic fluid around the Patient's liver. The resident on duty at the time of the interpretation, Dr. Bhandarker once again, notified the Respondent that a study for Patient B revealed abdominal ascites and abnormal bowel findings. As to Patient C, the Committee found that the Respondent deviated from medically accepted standards in failing to identify evidence of diverticulitis in Patient C. The Committee found further that the Respondent deviated from medically accepted care standards by failing to identify a sacral lesion in Patient D and an abnormality in the right lower quadrant that was possibly appendicitis. In addition, the Committee found that the Respondent deviated from medically accepted care standards in failing to identify a soft tissue mass in the right lower quadrant of the abdomen of Patient E. Finally, the Committee found that the Respondent

deviated from accepted care standards in that he failed to identify a closed loop bowel obstruction in Patient F.

The Committee found that the deviations from accepted care standards amounted to practice with negligence on more than one occasion for each Patient A-E. The Committee based their findings on testimony by Ellen L. Wolf, M.D., the Petitioner's expert witness. The Committee found further that the Respondent's deviations from accepted care standards rose to the level of gross negligence in the treatment to Patients A, B, D and F. The Committee found that the Respondent practiced with incompetence on more than one occasion in the cases of Patients A, B, C and F. As to the interpretation involving Patient A, Dr. Wolf testified that the failure to identify the mass amounted to a substantial deviation because the mass could be easily seen and the failure to diagnose could have significant consequences for the Patient. As to the study for Patient B, Dr. Wolf found serious deviation because the ascites could be easily seen and could be of great significance to the Patient. Dr. Wolf testified that the failure to identify the appendicitis in Patient D amounted to a serious departure from the accepted care standard because the study showed an obvious abnormality in the right lower quadrant of the abdomen. As to Patient F, Dr. Wolf testified that the Respondent's failure to identify the closed bowel loop constituted a serious deviation from the standard of care. The Committee noted that surgery is generally necessary for a small bowel obstruction, but especially for a closed loop.

The Committee voted to suspend the Respondent's License for three years and to stay the entire suspension. The Committee placed the Respondent on probation, with specific requirements for retraining under the supervision of the Office for Professional Medical Conduct (OPMC). The Committee found the Respondent's general radiology skills adequate, but found that the record shows that the Respondent experiences difficulty in reading CT scans. The retraining/probation terms appear at Appendix II to the Committee's Determination. The retraining requires a Clinical Competence Assessment, followed by a remediation program under a preceptor. The Respondent must complete the remediation program within three to twelve months. The retraining terms restrict the Respondent to practice in an institutional setting under a

practice monitor during the remediation. Following the remediation, the Respondent must serve two years on probation under further practice monitoring.

Review History and Issues

The Committee rendered their Determination on August 12, 2008. This proceeding commenced on August 28 & September 2, 2008, when the ARB received first the Respondent's and then the Petitioner's Notices requesting Review. The record for review contained the Committee's Determination, the hearing record, the Petitioner's brief and reply brief and the Respondent's brief and reply brief. The record closed when the ARB received the Petitioner's response brief on October 27, 2008.

The Respondent argued that the record failed to support the Committee's findings, that the Committee set an impossible care standard for radiologists and that the Committee imposed an excessive penalty. The Respondent requested that the ARB remove any sanction against the Respondent.

The Petitioner requests that the ARB increase the sanction that the Committee imposed by barring the Respondent from reading CT scans during the retraining period, by placing the Respondent on probation for three full years following the retraining and by requiring more intense practice monitoring during the first year of probation, following the retraining.

ARB Authority

Under PHL §§ 230(10)(i), 230-c(1) and 230-c(4)(b), the ARB may review Determinations by Hearing Committees to determine whether the Determination and Penalty are

consistent with the Committee's findings of fact and conclusions of law and whether the Penalty is appropriate and within the scope of penalties which PHL § 230-a permits. The ARB may substitute our judgment for that of the Committee, in deciding upon a penalty Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993); in determining guilt on the charges, Matter of Spartalis v. State Bd. for Prof. Med. Conduct 205 A.D.2d 940, 613 NYS 2d 759 (3rd Dept. 1994); and in determining credibility, Matter of Minielly v. Comm. of Health, 222 A.D.2d 750, 634 N.Y.S.2d 856 (3rd Dept. 1995). The ARB may choose to substitute our judgment and impose a more severe sanction than the Committee on our own motion, even without one party requesting the sanction that the ARB finds appropriate, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). In determining the appropriate penalty in a case, the ARB may consider both aggravating and mitigating circumstances, as well as considering the protection of society, rehabilitation and deterrence, Matter of Brigham v. DeBuono, 228 A.D.2d 870, 644 N.Y.S.2d 413 (1996).

The statute provides no rules as to the form for briefs, but the statute limits the review to only the record below and the briefs [PHL § 230-c(4)(a)], so the ARB will consider no evidence from outside the hearing record, Matter of Ramos v. DeBuono, 243 A.D.2d 847, 663 N.Y.S.2d 361 (3rd Dept. 1997).

A party aggrieved by an administrative decision holds no inherent right to an administrative appeal from that decision, and that party may seek administrative review only pursuant to statute or agency rules, Rooney v. New York State Department of Civil Service, 124 Misc. 2d 866, 477 N.Y.S.2d 939 (Westchester Co. Sup. Ct. 1984). The provisions in PHL §230-c provide the only rules on ARB reviews.

Determination

The ARB has considered the record and the parties' briefs. The ARB affirms the Committee's Determination on the charges and we affirm the Committee's Determination to suspend the Respondent's License, to stay the suspension, to place the Respondent on probation and to order the Respondent to undergo retraining.

The Respondent argued that the record failed to support the Committee's findings. The record, however, contained the expert testimony by Dr. Wolf, on which the Committee based their findings. The record also contained testimony by Dr. Bhandarkar to indicate that she discussed with the Respondent both the mass in the study for Patient A and the ascites in the study for Patient B. The Respondent presented expert testimony by Harris L. Cohen, M.D. The Committee's Conclusions listed several references to testimony by Dr. Cohen that supported the charges against the Respondent. For example, in the study on Patient B, Dr. Cohen admitted that ascites were present. In discussing the study on Patient E, Dr. Cohen conceded that there was soft tissue density. The ARB defers to the Committee as the fact finder in the Committee's decisions as to which witnesses the Committee found credible. The evidence which the Committee cited as credible demonstrated that the Respondent practiced with negligence on more than one occasion, gross negligence and incompetence on more than one occasion. The ARB affirms the Committee's Determination on the charges.

The Respondent also argued that the Committee set an impossible standard of care for radiologists. The ARB concludes that the Committee set no such standards. The Committee found that the Respondent failed to practice according to the existing standard of care and the Committee relied on expert testimony in the record to determine the existing care standards. The Committee limited their findings to the facts in this case and the Committee limited the sanction

in this case to those steps the Committee found necessary to address the Respondent's problems with reading CT scans.

Both parties challenge the Committee's Determination on the sanction. The ARB affirms the Committee's Determination to impose a stayed suspension with retraining and probation. The ARB finds nothing excessive in the Committee's Determination. The ARB limited the retraining to CT scans and allowed the Respondent to remain in practice, with a preceptor and a monitor during retraining. The Committee also imposed a reasonable period on probation, to determine whether the Respondent has benefited from the retraining and corrected his deficiencies. The ARB finds no need to impose more stringent monitoring or to extend the probation period.

ORDER

NOW, with this Determination as our basis, the ARB renders the following ORDER:

1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB affirms the Committee's Determination to suspend the Respondent's License for three years, to stay the suspension in full, to order that the Respondent undergo retraining and place the Respondent on probation following the retraining, under the terms that appear at Appendix II to the Committee's Determination.

Thea Graves Pellman
Datta G. Wagle, M.D.
Linda Prescott Wilson
Therese G. Lynch, M.D.

In the Matter of Sheldon Lewis Wieder, M.D.

Linda Prescott Wilson, an ARB Member concurs in the Determination and Order in the Matter of Dr. Wieder.

Dated: February 10, 2009

Redacted Signature

Linda Prescott Wilson

In the Matter of Sheldon Lewis Wieder, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Wieder.

Dated: February 12, 2009

Redacted Signature

Thea Graves Pellman

In the Matter of Sheldon Lewis Wieder, M.D.

Datta G. Wagle, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Wieder.

Dated: 2/12/, 2009

Redacted Signature

Datta G. Wagle, M.D.

In the Matter of Sheldon Lewis Wieder, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Wieder.

Dated: Feb 10, 2009

Redacted Signature

Therese G. Lynch, M.D.