NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

PETER E. GRAHAM, M.D.

MODIFICATION

ORDER

BPMC No.#96-63

Upon the proposed Application for a Modification Order of **PETER E. GRAHAM, M.D.**, (Respondent), that is made a part of this Modification Order, it is agreed and

ORDERED, that the attached Application and its terms are adopted and it is further

ORDERED, that this Modification Order shall be effective upon issuance by the Board, either by mailing, by first class mail, a copy of the Modification Order by first class mail to Respondent at the address in the attached Application or by certified mail to Respondent's attorney or upon transmission via facsimile to Respondent or Respondent's attorney, whichever is earliest.

SO ORDERED.

DATED: 10-30-2008

Redacted Signature

KENDRICK A. SEARS, M.D.
Chair
State Board for Professional
Medical Conduct

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

IN THE MATTER

OF

PETER E. GRAHAM, M.D.

APPLICATION FOR

MODIFICATION ORDER

PETER E. GRAHAM, M.D., (Respondent) being duly sworn deposes and says:

That on or about November 21, 1974, I was licensed to practice as a physician in the State of New York, having been issued License No. 122507 by the New York State Education Department.

My current address is Redacted Address

I am currently subject to Order BPMC #96-63, (hereinafter "Original Order"), annexed hereto, made a part, hereof, and marked as Exhibit 1, that was issued on March 18, 1996, that accepted the Findings of Determination and Order BPMC-95-204.

I apply, hereby, to the State Board for Professional Medical Conduct for a Modification Order (hereinafter "Modification Order"), modifying the Original Order and Determination and Order BPMC-95-204, as follows: to delete the paragraph in the Original Order and Determination and Order BPMC-95-204 that states:

" 3) The Respondent can only provide emergency services, under supervision."

The Modification Order to be issued will not constitute a new disciplinary action against me.

I make this Application of my own free will and accord and not under duress, compulsion or restraint, and seek the anticipated benefit of the requested Modification. In consideration of the value to me of the acceptance of the Board of this Application, I knowingly waive the right to contest the Original Order or the Modification Order for which I apply, both administratively and judicially, and ask that the Board grant this Application.

I understand and agree that the attorney for the Bureau of Professional Medical Conduct, the Director of the Office of Professional Medical Conduct, and the Chair of the State Board for Professional Medical Conduct each retain complete discretion to either enter into the proposed Agreement and Modification Order, based upon my application, or to decline to do so. I further understand and agree that no prior or separate written or oral communication can limit that discretion.

AFFIRMED:

DATED: 10/14/08

Redacted Signature

PETER E. GRAHAM, M.D.
Respondent

The undersigned agree to the attached Application of Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 17 October 2008

Redacted Signature

ROBERT BOGAN
Associate Counsel
Bureau of Professional Medical Conduct

DATE: 10/29/08

Redacted Signature

KEITH W. SERVIS
Director
Office of Professional Medical Conduct

EXHIBIT 1

New York State Board for Professional Medical Conduct
Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Charles J. Vacanti, M.D.
Chair

March 26, 1996

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Peter E. Graham, M.D.
Redacted Address

Re: License No.122507
Effective Date: 04/02/96

Dear Dr. Graham:

Enclosed please find Order #BPMC 96-63 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

If the penalty imposed by the Order is a surrender, revocation or suspension of this license, you are required to deliver to the Board the license and registration within five (5) days of receipt of the Order.

Board for Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Tower Building-Room 438
Albany, New York 12237-0756

Sincerely,

Redacted Signature

Charles J. Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure
cc: Anthony Z. Scher, Esq.
Wood & Scher
The Harwood Building
Scarsdale, New York 10583

Joseph Huberty, Esq.

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER :

OF : ORDER

PETER E. GRAHAM, M.D. : BPMC #96-63

Upon the application of PETER E. GRAHAM, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: March 15, 1996

Redacted Signature

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
----------X

IN THE MATTER	:	APPLICATION
OF	:	FOR CONSENT
PETER E. GRAHAM, M.D.	:	ORDER

----------X

STATE OF NEW YORK)
COUNTY OF WESTCHESTER) ss.:

PETER E. GRAHAM, M.D., being duly sworn, deposes and says:

That on or about November 21, 1974 I was licensed to practice as a physician in the State of New York, having been issued license No. 122507 by the New York State Education Department.

My current address is 19 Old Pascack Road, Woodcliff, New Jersey and I will advise the Director of the Office of Professional Medical Conduct of any change in my address.

The New York State Board For Professional Medical Conduct has charged me with five (5) Specifications of professional misconduct relating to my treatment of two (2) patients. The Statement of Charges is annexed hereto, marked Exhibit "B" and made a part hereof by reference.

During the months of February and March of 1995 a committee appointed by The New York State Board For Professional Medical Conduct held hearings concerning the charges set forth in the Specification of Charges. The hearing committee sustained three (3) of Specifications set forth in the Statement of Charges and

did not sustain two (2) of the Specifications stated therein. A copy of the Hearing Committee report and determination is annexed hereto, marked Exhibit "A" and made a part hereof by reference.

The penalty imposed upon me by the hearing committee was: 1) that my license to practice medicine in New York State be suspended for a period of two (2) years. However, the suspension was "stayed" in its entirety on condition that I abide with the Terms of Probation (Exhibit "C") hereinafter referred to; 2) that I be placed on Probation for a period of two (2) years under the Terms of Probation annexed hereto, marked Exhibit "C" and made a part hereof by reference; and 3) that hereafter I can practice Emergency Medicine in New York State only under supervision.

I challenged the hearing committee's determination in a proceeding commenced in the Appellate Division, Third Department pursuant to Article 78 of the CPLR and Section 230-c of the Public Health Law on various grounds including the fact that the hearing committee based its determination on a legally incorrect standard of proof. The papers submitted to the Appellate Division are appended hereto, marked Exhibit "D" and made apart hereof by reference. My CPLR Article 78 proceeding is still pending and has been before the Appellate Division since September 12, 1995.

I now wish to resolve this matter without further proceedings. Accordingly I agree to accept the findings of the hearing committee, the penalties imposed by the hearing committee and the probation and terms thereof attached to and made a part

of the determination and order of the hearing committee dated August 31, 1995.

I agree to withdraw my Article 78 proceeding with prejudice within fifteen (15) days following final approval of this application and I agree to take no further appeals of any kind challenging the determination of the hearing committee.

It is my further understanding that, in consideration of the foregoing, the Office of Professional Medical Conduct has agreed not to take any appeal from the determination of the hearing committee.

I hereby make this application to the State Board For Professional Medical Conduct (the Board) and request that it be granted.

I understand that in the event this application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged, charged or sustained against me. Such application shall not be used against me in any way and shall be kept in strict confidence. I further understand that in the event that this application is not granted, I shall be permitted to continue pursuing the pending Article 78 proceeding and to make whatever arguments therein that I deem appropriate, and the Office Of Professional Medical Conduct shall be permitted to make whatever arguments in opposition to said proceeding that it deems appropriate.

I agree that in the event the Board grants my application as

set forth herein, an order of the Chairperson of the Board shall be issued in accordance with the provisions hereof.

I am making this application of my own free will and accord and not under duress, compulsion, or restraint of any kind or manner and in consideration of the value to me of the acceptance by the Board of this application allowing me to resolve this matter without the various risks and burdens of an Article 78 proceeding and/or a remand hearing.

I knowingly waive any right I may have to contest the consent order for which I hereby apply, whether administratively or judicially.

Redacted Signature

PETER E. GRAHAM, M.D.

Sworn to before me this
1ST day of ~~January~~ March, 1996

Redacted Signature

Notary Public, State of New York
My Comm. Exp.

MOHINDER S. GULATI
Notary Public, State of New York
No. 31-4659357
Qualified in New York County
Commission Expires Nov. 30, 1996

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

IN THE MATTER	:	APPLICATION
OF	:	FOR CONSENT
PETER E. GRAHAM, M.D.	:	ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

Dated: January , 1996

Redacted Signature

PETER E. GRAHAM, M.D.,
RESPONDENT

Dated: January 24 , 1996

Redacted Signature

ANTHONY Z. SCHER
ATTORNEY FOR RESPONDENT

Dated: ~~January~~ March 11, 1996

Redacted Signature

JOSEPH HUBERTY, Asst. Counsel
BUREAU OF PROFESSIONAL MEDICAL CONDUCT

Dated: January , 1996

Redacted Signature

ANNE SAILE, DIRECTOR
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

Dated: ~~January~~ March 18, 1996

Redacted Signature

CHARLES J. VACANTI, M.D.
CHAIRPERSON, STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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

IN THE MATTER

OF

PETER GRAHAM, M.D.

DETERMINATION

AND

ORDER

BPMC-95-204

The undersigned Hearing Committee consisting of BENJAMIN WAINFELD, Chairperson, F. MICHAEL JACOBIUS M.D., and ANTHONY SANTIAGO, were duly designated and appointed by the State Board for Professional Medical Conduct. MARY NOE, ESQ., Administrative Law Judge, served as Administrative Officer.

The hearing was conducted pursuant to the provisions of Sections 230 (10) of the New York Public Health Law and Sections 301-307 of the New York State Administrative Procedure Act to receive evidence concerning alleged violations of provisions of Section 6530 of the New York Education Law, by PETER GRAHAM, M.D. (hereinafter referred to as "Respondent"). Witnesses were sworn or affirmed and examined. A stenographic record of the hearing was made. Exhibits were received in evidence and made a part of the record.

The Committee has considered the entire record in the above captioned matter and hereby renders its decision with regard to the charges of medical misconduct.

EXHIBIT "A"

The Respondent was charged with negligence on more than one occasion, gross negligence, incompetence on more than one occasion, gross incompetence and failure to keep accurate records. The charges are set forth in the Notice of Hearing and Statement of Charges attached as Appendix I.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	December 22, 1994
Pre-Hearing Conferences:	January 25, 1995
Hearing dates:	February 2, 1995 March 15, 1995 March 16, 1995 March 28, 1995
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberation:	April 11, 1995
Petitioner appeared by:	Jerome Jasinski, Esq. Acting General Counsel BY: Joseph Hubberty, Esq. Assistant Counsel NYS Department of Health
Respondent appeared by:	Anthony Scher, Esq. Wood & Scher Attorneys At Law 14 Harwood Court - Suite 512 Scarsdale, NY 10583

WITNESSES

For the Petitioner:

William Maliha, M.D

For the Respondent:

Leviton, M.D.,
Peter Graham, M.D., the Respondent

SIGNIFICANT LEGAL RULINGS

The Administrative Law Judge issued instructions to the Committee with regard to the definitions of medical misconduct as alleged in this proceeding. The Administrative Law Judge instructed the Panel that negligence is the failure to use that level of care and diligence expected of a prudent physician and thus consistent with acceptable standards of medical practice in this State. Gross negligence was defined as a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount to egregious conduct. The panel was told that the term egregious means a conspicuously bad act or severe deviation from standards.

With regard to the expert testimony herein, including Respondent's, the Committee was instructed that each witness should be evaluated for possible bias and assessed according to his or her training, experience, credentials, demeanor and credibility.

PRELIMINARY STATEMENT

The following findings of fact were made after a review of the entire record. Numbers in parenthesis (T.) refer to transcript pages or numbers of exhibits (Ex.) in evidence. These citations represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Evidence or testimony which conflicted with any finding of this Hearing Committee was considered and rejected. Some evidence and testimony was rejected as irrelevant. The Petitioner was required to meet the burden of proof by a substantial evidence.

FINDINGS OF FACT

1. Peter Graham, M.D., Respondent, was authorized to engage in the practice of medicine in the State of New York.

PATIENT A

2. On June 21, 1992, Dr. Graham's worked in the emergency room at the Columbia-Greene Medical Center, Greene Division from 7:00 p.m. to 7:00 a.m. (T. 360)
3. Patient "A" arrived in the emergency room on June 21, 1992, at 2:03 AM and remained in Dr. Graham's care until 7:00 AM. (T. 340)

4. Prior to arriving at the hospital, Patient "A" was treated by the paramedics in the ambulance. (Ex. IIA and III)

5. The Nurse's Triage Note notes that the left anterior chest sounds were greatly diminished and rales were noted in the right anterior chest. (T. 227) Her blood pressure was 190/100. (Ex. IIA, p.3)

6. The hospital record notes rales on all fields. (T 228; Ex. IIA)

7. Dr. Maliha testified that the x-ray indicates the cause of rales. (Ex. IIA, p.8, 15; T. 218; Ex. 8)

8. The medical record reflects that Dr. Eno, the emergency room doctor on June 22, 1992, from 7 am till 7 pm, notes rare rhonchi, which are course rales. (T. 231)

9. The Respondent failed to diagnose or treat Patient A for rales in the Patient's lungs.

10. Pre-Hospital report and Triage note indicates the whole chest cavity is full of fluid. (Ex. 2A, p. 3, 17, 18; T. 216)

11. Dr. Maliha testified that the patient's chest cavity was filled with fluid, the source of hypoxemia. (T. 207, 216)

12. The Nurse's Triage Note on Patient "A" states that she was diaphoretic, and that she showed signs of facial edema and pitting pedal edema. (Ex. IIA, III p. 3)

13. Dr. Maliha, after reviewing the entire Hospital Record, testified that Patient A had generalized edema pleural effusion and a fluid overload. (T. 216, 313)

14. Dr. Maliha testified that the lab results of the blood gases,

indicate hypoxemia, despite the four liters of oxygen the Patient was on at the time of the test. (Ex. IIA, p. 15, T. 217)

15. Dr. Graham's testified that Patient A showed generalized edema. (T. 419, 420, 466, 479, 486)

16. The Respondent failed to diagnose or treat Patient A for edema or hypoxemia.

17. The paramedics diagnosis was congestive heart failure. (T. p. 205; Ex. IIA and III)

18. Dr. Maliha testified that he agreed with the Radiology Division of the Hospital as to their diagnosis of congestive heart failure and that the patient was dying of acute respiratory failure probably caused by congestive heart failure. (T 217; Ex. IIA p.11)

19. The Respondent failed to diagnose or treat Patient A for congestive heart failure.

20. Dr. Maliha testified that patient A who was hypoxic and acidotic and needed at a very minimum high flow oxygen of at least ten liters per minute. (T. 207, 311)

21. The Respondent treated Patient A with 4 liters of oxygen. (Ex. IIA; T. 15)

22. The Respondent failed to order adequate supportive oxygen services for Patient A.

23. The Pre-Hospital Report noted that Patient "A" was diabetic, had renal disease, and she was taking several medications which were for a cardiac condition. (Ex. IIA and III)

24. The Respondent failed to observe or note the nature of the medications taken by Patient A prior to admission. (T 208; Ex. IIA p 20, 21).

25. Dr. Maliha testified that after reviewing the laboratory tests, Patient A's blood gas at 2:20 AM was 48, which is essentially incompatible with prolonged life and a PCO2 of 54 which indicates that the Patient was acutely or rapidly decompensating. (T. 205; Ex. 8)

26. Dr. Maliha testified that the Patient's past medical history indicated that she had a stroke in the past and she was hypertensive. Chest xray, EKG and laboratory test results indicated a definite cardiovascular problem that needed immediate treatment. (T. 209)

27. The Petitioner failed to develop a medical plan for treatment. (T. 479, 491, 493)

28. Prior to arriving at the hospital, the paramedics treated Patient "A" with oxygen, Lasix, and nitroglycerin. (Ex. IIA and III; T. 204)

29. Respondent failed to render any active or affirmative medical care, or offer any interventions to alleviate Patient A's condition, except for oxygen. (T. 206)

30. Respondent failed to administer or order any diuretic for Patient A. (Ex. IIA, p. 3, 4; Ex. 8)

31. The Respondent failed to treat Patient A for fluid overload and congestive failure.

32. Dr. Maliha, after reviewing the results of the pulse oxymetry, testified that Patient A was not stabilized at the time Dr. Graham authorized transfer of the patient. (T. 311)

33. The Respondent authorized and directed transport of Patient A without first stabilizing Patient A.

PATIENT "B"

34. On January 12, 1992 Patient B came to the hospital's emergency room via ambulance following a skiing accident wherein he skied into a tree. (Ex. 3, p. 15)

35. Patient B was found by the ski patrol unconscious and unresponsive (Ex. 3, p. 15)

36. The ambulance crew noted the following conditions: his skin was warm and moist, respiration rate was 24 at 11:06 a.m. and 20 at 11:22, pulse at 97 at 11:06; 98 at 11:22, blood pressure 140/p. (Ex. 3, p. 15)

37. The ambulance crew started an intravenous line of Lactated Ringers. (Ex. 3, p. 16)

38. Patient B arrived in the emergency room at about 11:33 a.m. conscious, confused and combative. (Ex. III, p. 15 and 16)

39. An examination of Patient B revealed a laceration of the skull, deformed right leg, blood mixed with stool and epigastric pain. (Ex. III)

40. Dr. Mahila testified that after reviewing Patient B's medical chart for blood pressure recorded from 12:00 PM to 12:30 PM, Patient B was in shock and near death. (T. 22)

41. Dr. Mahila testified that within 30 minutes after Patient B arrived he was in hypovolemic hemorrhagic shock. (Ex. 3, p. 4, 8, 9, 11, 12; T. 21, 34, 37, 40, 58)

42. The Respondent failed to identify and treat Patient B for hypovolemic shock.

43. Dr. Mahila testified that the Respondent never recognized in the medical record that Patient B had been suffering from acute rapid intra-abdominal, life threatening hemorrhage with shock. (T 26, 35, 36, 37)

44. The Respondent failed to develop an accurate diagnosis or a treatment plan for Patient B. (Ex. 3, p.4, 6, 7, 8 , 9,11, 12)

45. The Respondent notes in the medical record that there is blood in the rectum and later when a tube is placed in the Patient's stomach, there was blood. (T. 27, 33)

46. The Respondent failed to give the Patient adequate fluid replacement. (T. 27, 33)

47. Respondent failed to note and address Patient B's tachycardia condition. (Ex.3, p.4; T.52,35; Ex.3; T. 8, 9,11,12,41,57)

DISCUSSION

The Hearing Committee found the prosecutor's expert witness, Dr. Maliha, in direct contradiction to the Respondent's expert witness, Dr. Leviton. During his testimony, Dr. Leviton explained that the specimen of blood analyzed for Patient A was probably not pure arterial blood (T 690-1). Dr. Leviton's testimony was discredited since Dr. Graham never agreed with such a theory and testified that he chose to completely ignore the abnormal laboratory results. Therefore, this panel accepts the expert testimony of the prosecutor's expert witness.

The Panel had two of the same hospital reports on Patient A that were certified at different times by the same hospital to be the complete record to use as Exhibit II and Exhibit IIA. Exhibit IIA was identical to Exhibit II except for the following differences (T 238):

Exhibit II p. 20 the notation of "rales" is missing

Exhibit IIA has seven additional pages

The Panel reviewed both and considered the significance of the missing pages and the deletions on any documents.

The panel examined the totality of the evidence and testimony. As to Patient A, there are abnormal laboratory test results as well as significant abnormal blood gas test results (IIA, p. 3, 5, 11, 12, 15, 18, 19, 20). The above laboratory findings indicated a significant cardiac overload. Proper treatment called for urgent diuretic therapy. (T. 495; T. 208).

DECISION

The Hearing Committee **SUSTAINED** the following factual allegations:

Allegation A, 1, 2, 3, 4, 5, 6, 7

Allegation B, 1, 3, 4

The Hearing Committee did **NOT SUSTAIN** the following allegation:

Allegation B.2.

The Committee agreed unanimously that the Respondent is guilty of:

Specification 1: Negligence on more than one occasion -

SUSTAINED

Specification 2: Gross negligence on more than one occasion -

SUSTAINED

Specification 5: Failure to keep adequate records -

SUSTAINED

The Committee agreed unanimously that the Respondent is <u>not</u> guilty of:

Specification 3: Incompetence on more than one occasion -

NOT SUSTAINED

Specification 4: Gross incompetence on more than one occasion

NOT SUSTAINED

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. Suspension of the physician's license for two (2) years, which is stayed; and

2. The Respondent will be on probation, conditions of probation attached (Appendix II); and

3. The Respondent can only provide emergency services, under supervision.

DATED: New York, New York
8/31, 1995

Redacted Signature

BENJAMIN WAINFELD, M.D.

F.MICHAEL JACOBIUS, M.D.
ANTHONY SANTIAGO

NEW YORK STATE DEPARTMENT OF HEALTH