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

August 12, 2008

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 Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the 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.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), (McKinney Supp. 2007) and §230-c subdivisions 1 through 5, (McKinney Supp. 2007), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the Respondent or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Redacted Signature

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER OF SHELDON LEWIS WIEDER, M.D.	DETERMINATION AND ORDER

BPMC #08-151

CALVIN J. SIMONS, M.D., Chairperson, **MANGALA RAJAN, M.D.** and **RANDOLPH H. MANNING, Ph.D,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law.

CHRISTINE C. TRASKOS, ESQ., served as Administrative Officer for the Hearing Committee. The Department of Health appeared by **THOMAS CONWAY.,** General Counsel, **PAUL STEIN, ESQ.,** Associate Counsel, of Counsel. The Respondent appeared by **NIXON PEABODY LLP, DANIEL J. HURTEAU, ESQ.,** of Counsel. Evidence was received and witnesses sworn and heard and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

STATEMENT OF CHARGES

The accompanying Statement of Charges alleged six (6) specifications of professional misconduct, including allegations of negligence, gross negligence and incompetence. The charges are more specifically set forth in the Statement of Charges dated January 25, 2008, a copy of which is attached hereto as Appendix I and made a part of this Determination and Order.

SUMMARY OF PROCEEDINGS

Notice of Hearing Date:	January 25, 2008
Pre-Hearing Conference	February 19, 2008
Hearing Dates:	February 27, 2008
	March 25, 2008
	May 6, 2008
	May 13, 2008

WITNESSES

For the Petitioner:	Ellen L. Wolf, M.D. Priya Bhandarkar, M.D. Bernard Birnbaum, M.D. Dorothy Zelenik Alex Megibow, M.D.
For the Respondent:	Sheldon Wieder, M.D. Barbara Wieder Harris Cohen, M.D.

FINDINGS OF FACT

1 Respondent, was authorized to practice medicine in New York State on or about July 22, 1968, by the issuance of license number 101867 by the New York State Education Department. (Dept.'s Ex. 2)

Patient A

2. On or about July 24, 2003 and May 24, 2004, the Respondent, a radiologist, interpreted CT scans of the abdomen, pelvis and chest of Patient A at the New York University Medical Center, New York, New York. On or about May 24, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient A that had been performed for the clinical indication of "lower abdominal pain, evaluate for aortic dissection." Priya Bhandarkar, M.D., a resident who preliminarily evaluated the CT scan, informed Respondent that, in her opinion, the film revealed an exophytic mass in the right kidney. (Dept.'s Ex. 4, 10, 16, Resp.'s Ex. B, C, D, F; T. 30-31, 173-75)

3. Respondent deviated from medically accepted standards in that he interpreted Patient A's kidneys as "normal". (Dept.'s Ex. 4, 10, 16, Resp.'s Ex. C, D, F; T. 31-33)

4. At hearing, Respondent admitted that he missed a mass in the upper pole of Patient A's right kidney. (T. 547-48)

5. On 6/7/04, in discussing his misinterpretation of 2 cases with Haskel Fleishaker, M.D., chief of emergency radiology at NYU Medical Center, Respondent could not explain why he did not report Patient A's kidney mass in his initial written report because he believed it was normal. (Resp's Ex. D; T. 198)

6. On the evening of 5/24/04, in the Emergency Department, Dr. Bhandarkar notified Respondent, covering attending that night, that Patient A's chest CT dissection study revealed an exophytic mass worrisome for neoplasm arising from the upper pole of the

right kidney. Dr. Wieder specifically told her that the finding represented heterogeneous renal enhancement, was not a tumor and should be dictated as a suspicious mass. Dr. Bhandarkar reviewed the findings the next day with Dr. Alec Megibow, covering attending on the abdominal service. (Resp's Ex. F; T. 174-77)

7. Respondent dictated the original report. (T. 175-76)

8. It is the custom and practice that if an attending radiologist's name and a resident's name are on a CT report, the attending radiologist is ultimately responsible for the report. (T. 102)

9. Dr. Bhandarkar was the resident on call the night of May 24, 2004. (T. 173)

10. Dr. Bhandarkar discussed Patient A's case and her disagreements with Respondent with Bernard Birnbaum, M.D. in a telephone call a few days later. (Resp's Ex. F; T. 176-77, 278)

11. Alec Megibow, M.D. prepared the addendum to Patient A's CT report without consulting or involving Respondent because Respondent was not on duty the next morning when Dr. Megibow reviewed it, and there was a significant finding that was not made in the initial interpretation that needed to be conveyed to the physicians that were taking care of Patient A. This finding was a renal cancer, a hypernephroma, that is described in the report as a mass in the upper pole of the right kidney on image 55. It is an important, significant finding, because it is a cancer that would have to be evaluated for definitive therapy. (Dept.'s Ex. 10; T. 578-79)

12. Patient A's CT scan is of diagnostic quality. (Dept.'s Ex. 4; T. 32, 43)

13. Respondent's CT report for Patient A does not accurately reflect the findings in the CT. It fails to mention a mass in the upper pole of the right kidney. It most likely represents renal cell carcinoma. What should be done when such a mass is noted would depend on the clinical circumstances, but in general, surgery should be done. Failure to note and follow up on such a mass could result in the mass growing and possibly metastasizing to other parts of the body. (Dept.'s Ex. 4, 10; T. 31-32)

14. Missing the mass in Patient A's right kidney is a serious departure from the standard of care, because it is easily seen and could have significant consequences for the patient, if not diagnosed. (Dept.'s Ex. 4, 10; T. 40)

15. It is unlikely that someone would miss the kind of mass that Patient A had, given the number of slices there were in looking for an aortic aneurysm. (Dept.'s Ex. 4, 10; T. 63)

16. It is normal practice, even though indication is aortic dissection, to look at every other organ on the CT scan and dictate all significant abnormalities in the study. It would be a deviation from the medical standard not to report a matter of significance on a radiological study. (Dept.'s Ex. 4, 10; T. 64-65)

17. When Dr. Bhandarkar told Respondent that Patient A had a mass in the right kidney, Respondent said he thought it was not a mass, it was not something abnormal in the right kidney, it was just a normal finding. Respondent told Dr. Bhandarkar that the finding represented heterogeneous renal enhancement, was not a tumor, and should not be dictated as a suspicious mass. (Resp's Ex. F; T. 174-75)

Patient B

18. On or about May 24, 2004, the Respondent evaluated a CT scan of the chest of Patient B that had been performed for the clinical indication of pulmonary embolus. Priya Bhandarkar, M.D., a resident who preliminarily evaluated the CT scan, informed Respondent that in her opinion the film revealed ascites in the upper abdomen. (Dept.'s Ex. 5, 11, 16, Resp's Ex. B, C, D, F; T. 67, 74-75, 219-22)

19. Respondent deviated from medically accepted standards in that he concluded that the images of the upper abdomen of Patient B were "unremarkable". (Dept.'s Ex. 5, 11, 16, Resp's Ex. B, C, D, F; T. 67-68)

20. On 6/7/04, in discussing his misinterpretation of 2 cases with Haskel Fleishaker, M.D., chief of emergency radiology at NYU Medical Center, Respondent could not explain why he did not report Patient B's abdominal ascites and significant small bowel dilatation in his initial written report. (Resp's Ex. D; T. 198)

21. On the evening of 5/24/04, in the Emergency Department, Dr. Bhandarkar notified Respondent, covering attending that night, that Patient B's chest CT study revealed abdominal ascites and abnormal bowel loops. Respondent specifically told her that the finding represented normal abdominal fat and not ascites and should be reported as such. He was not impressed with the bowel findings. Dr. Bhandarkar reviewed the findings the next day with Dr. Alec Megibow, covering attending on the abdominal service. (Resp's Ex. F; T. 219-22)

22. Dr. Bhandarkar discussed Patient B's case and her disagreements with Respondent with Bernard Birnbaum, M.D. in a telephone call a few days later. (Resp's Ex. F; T. 176-77, 278)

23. Alec Megibow, M.D. prepared the addendum to Patient B's CT report because one of the statements in the original reports is incorrect. The incorrect statement is images of the upper abdomen are unremarkable. It requires a work up to be explained. (Dept.'s Ex. 11; T. 588-90)

24. Patient B's CT scan is of diagnostic quality. (Dept.'s Ex. 5; T. 67)

25. Respondent's CT report for Patient B is not accurate. It states that the images of the upper abdomen are unremarkable and there is ascites present in the upper abdomen. Not noting the ascites is a departure from the standard of care. Ascites can be due to many different things. In this case it's not clear what it's due to. Further evaluation of the patient's medical condition to determine the etiology of the ascites would be required. Failure to note ascites on Patient B's CT's is a severe departure from the standard of care. It is easily seen, and it could be of great significance to the patient. It is not a subtle finding. (Dept.'s Ex. 5, 11; T. 67-69)

26. When Dr. Bhandarkar told Respondent that Patient B's chest study revealed abdominal ascites and abnormal bowel loops, Respondent told her that the finding represented normal abdominal fat and not ascites, and should not be reported as such. Respondent said that there was not really any fluid. (Resp's Ex. F; T. 220-21)

Patient C

27. On or about February 15, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient C for the clinical indication of lower abdominal pain and a history of diverticulitis and tubo-ovarian abscess. (Dept.'s Ex. 6, 12, 16, Resp's Ex. B; T. 83-84)

28. Respondent deviated from medically accepted standards in that he concluded that there was no radiologic evidence of diverticulitis in Patient C. (Dept.'s Ex. 6, 12, 16, Resp's Ex. B; T. 84-85, 101)

29. Respondent admitted in retrospect that the Department's expert witness, Ellen Wolf, M.D., was correct in saying that Respondent should have identified Patient C's diverticulitis. (T. 645-46)

30. Patient C's CT scan is of diagnostic quality. (Dept.'s Ex. 6; T. 84)

31. It was a departure from the standard of care for Respondent to state in Patient C's CT report that there is no evidence of diverticulitis. It is not possible to say that there is no evidence of diverticulitis because the colon is very thickened and there is infiltration around it. (Dept.'s Ex. 6, 12; T. 84-85)

32. "There is no evidence of diverticulitis" is not an accurate statement. (Dept.'s Ex. 6; T. 101)

Patient D

33. On or about February 4, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient D that had been performed for the clinical indication of abdominal pain. (Dept.'s Ex. 7, 13, 16, 17, Resp's Ex. B; T. 107-108)

34. Respondent deviated from medically accepted standards in that he failed to identify an abnormality in the right lower quadrant of Patient D, most likely appendicitis. (Dept.'s Ex. 7, 13, 16, 17, Resp's Ex. B; T. 108-110)

35. Respondent deviated from medically accepted standards in that he failed to identify a sacral lesion in Patient D. (Dept.'s Ex. 7, 13, 16, 17, Resp's Ex. B; T. 116-118)

36. Respondent's expert, Dr. Harris Cohen testified that with the limited history and findings of right lower quadrant pathology, "statistically you always got to think appendicitis." (T. 866)

37. Patient D's CT scan is of diagnostic quality. (Dept.'s Ex. 7; T. 108)

38. Respondent's original CT report for Patient D is not accurate. It does not meet the standard of care. It states there is no suspicious mesenteric abnormality. Compressed mesenteric vessels are present. There is infiltration in the mesentery in the right lower quadrant. Probably appendicitis should have been mentioned in the report as a possibility. Failure to note any abnormalities would be a serious departure from the standard of care. (Dept.'s Ex. 7, 13; T. 108-110)

39. The first part of Respondent's CT report for Patient D, the paragraph that begins with the two words "Scoliotic patient" and ends with "Impression: Extended urinary bladder, no acute findings" is a serious departure from the standard of care, because there is obvious abnormality in the right lower quadrant of Patient D's abdomen. This is not a subtle finding. (Dept.'s Ex. 7, 13; T. 110-12)

40. Five days after Patient D's abdominal CT, an ultrasound was performed, which showed an inflamed appendix and a small fluid collection. (Dept.'s Ex. 17, p. 2; T. 126)

41. Respondent's failure to mention a sacral lesion in his original CT report for Patient D is a moderate departure from the standard of care. (Dept.'s Ex. 7, 13; T. 116-117)

42. There are risks involved in missing a sacral lesion. It is unclear what it is due to. It could be a benign or possibly a malignant lesion. There were risks involved in missing the abnormality in the right lower quadrant. There could be an inflammatory process, such as appendicitis. The risks of missing that could lead to perforation of the appendix, peritonitis, and possibly death. (T. 118)

Patient E

43. On or about September 14, 2003, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient E that had been performed for the clinical indication of lower abdominal pain. (Dept.'s Ex. 8, 14, 16, Resp's Ex. B; T. 133-34)

44. Respondent deviated from medically accepted standards in that he failed to identify a soft tissue mass in the right lower quadrant of the abdomen of Patient E. (Dept.'s Ex. 8, 14, 16, Resp's Ex. B; T. 134-35)

45. Respondent thought that his diagnosis regarding Patient E was correct. (T. 736-37)

46. Patient E's CT scan is of diagnostic quality. (Dept.'s Ex. 8; T. 134)

47. Respondent's CT report for Patient E does not accurately interpret the CT, and this is a departure from the standard of care. There is no mention of the soft tissue mass in the right lower quadrant. This was suspicious for a mass in the cecum, which could be cancer. The risk to the patient of not knowing this and following up on it is that if it were cecal cancer, it could grow and metastasize. This is a moderate departure. (Dept.'s Ex. 8; T. 134-35)

Patient F

48. On or about July 24, 2003, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient F for the clinical indication of acute periumbilical pain, nausea and vomiting. Patient F also had an elevated white count. (Dept.'s Ex. 9. 15, 16, 17, Resp's Ex. B; T. 148)

49. Respondent deviated from medically accepted standards in that he failed to identify a closed loop bowel obstruction in Patient F. (Dept.'s Ex. 9, 15, 16, 17, Resp's Ex. B; T. 148-49)

50. Respondent refused to acknowledge that he missed a diagnosis regarding Patient F. (T. 752)

51. Patient F's CT scan is of diagnostic quality. (Dept.'s Ex. 9; T. 148)

52. Respondent's CT report for Patient F is not accurate and the deficiencies in it are a departure from the standard of care. The report states there is no evidence for bowel obstruction, where in fact there is bowel obstruction, probably closed loop obstruction. Generally, surgery is necessary for small bowel obstruction, especially closed loop. This misdiagnosis is a severe deviation from the standard of care. (Dept's Ex. 9, 15, T. 148-149)

CONCLUSIONS OF LAW

Respondent is charged with six (6) specifications alleging professional misconduct within the meaning of Education Law § 6530. This statute sets forth numerous forms of conduct which constitute professional misconduct, but do not provide definitions of the various types of misconduct. During the course of its deliberations on

these charges, the Hearing Committee consulted a memorandum prepared by the General Counsel for the Department of Health. This document, entitled "Definitions of Professional Misconduct Under the New York Education Law", sets forth suggested definitions for gross negligence, negligence, gross incompetence, incompetence and the fraudulent practice of medicine.

The following definitions were utilized by the Hearing Committee during its deliberations:

Negligence is failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances.

Gross negligence is failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad.

Incompetence is a lack of the skill or knowledge necessary to practice the profession.

Using the above-referenced definition as a framework for its deliberations, the Hearing Committee concluded, by a preponderance of the evidence, that all six (6) specifications of professional misconduct should be sustained.

At the outset of deliberations, the Hearing Committee made a determination as to the credibility of various witnesses presented by the parties. Board-certified radiologist Ellen Wolf, M.D., Professor of Clinical Radiology, Albert Einstein College of Medicine and Associate Attending Radiologist, Montefiore Medical Center, was a credible witness for the Department. The Hearing Committee found her to be very unbiased and that she

answered questions in a direct and authoritative manner. (Dept.'s Ex. 3, Resp.'s Ex. B, C ; T. 24-160)

The Department also offered the testimony of Board-certified radiologist Priya Bhandarkar, M.D., who on the dates in question was a radiology resident at NYU Medical center, and at present is an assistant professor of radiology at SUNY Upstate Medical University. The Hearing Committee found her to be credible and believes that Dr. Bhandarkar advised Respondent of the adverse findings for Patients A and B. These conversations were corroborated by the testimony of Dr. Birnbaum.(Resp.'s Ex. F; T. 276, 280)

Board-certified radiologist Bernard A. Birnbaum, M.D., who is a tenured professor of radiology, senior vice president, vice dean and chief of hospital operations at the medical center testified for the Department. The Hearing Committee found Dr. Birnbaum to be a very credible, well organized and impressive witness who readily admitted when he did not know the answer to a question. (Resp's Ex. E, F; T. 244-400) The Hearing Committee further found Dorothy Zelenik, manager of medical staff services at NYU Medical Center, to be a credible but nervous witness who answered questions in a direct manner. (Resp's Ex. L, M, X; T. 410-487)

Board-certified radiologist Alec J. Megibow, M.D., a professor of radiology in the Department of Radiology at NYU Medical Center and School of Medicine and the director of faculty practice radiology also testified for the Department. (T. 572-598) The Hearing Committee found his testimony to be right to the point. Dr. Megibow explained why the addenda were made to Patient A and B's reports. While he does not specifically

recall speaking with Dr. Bhandarkar, it is his general practice in a teaching hospital to discuss cases with residents and make corrections to reports when necessary. (T. 576-577, 588-589)

Respondent offered the testimony of Board-certified radiologist, Harris L. Cohen, M.D. who at present is a tenured Professor of Radiology at SUNY Stoneybrook. He is also Vice Chairman of Research Affairs, Director of the division of body imaging and abdominal imaging fellowship and Chief of the sections of ultrasound and pediatric body imaging. (Resp.'s Ex. X; T. 768-769) The Hearing Committee found Dr. Cohen to be a very credible witness. At times he tried to avoid questions that were damaging to Respondent but when pushed for an answer, he was very forthcoming.

Mrs. Wieder also testified. The Hearing Committee found her not to be a credible witness. They note that Mrs. Wieder was unclear about the facts and did not answer questions directly. Respondent also took the stand on his own behalf. The Hearing Committee found that his testimony was not forthcoming and that Respondent frequently gave rambling answers with extraneous facts not pertinent to the question. As a result, the Hearing Committee found that Respondent was not a credible witness.

PATIENT A

Factual Allegations A and A.1: SUSTAINED

Dr. Wolf testified that Respondent's report failed to mention a mass in the upper pole of the right kidney, which was most likely a renal cell carcinoma. (T. 32) This mass was brought to his attention by the resident, Dr. Bhandarkar but Respondent still

disregarded it. Given the large number of slices on the scan, Dr. Wolf said it was not likely that this mass would be missed. The normal practice is to look at every other organ on the CAT scan even if the indication is for aortic dissection. (T. 63-64) Even Dr. Cohen stated that the radiologist has a responsibility to report significant findings that are not related to the primary request. (T. 803) Dr. Wolf testified that this was a serious deviation from the standard of care because the mass could be easily seen and it could have significant consequences for the patient if not diagnosed. (T. 40) As a result, the Hearing Committee finds that Respondent's failure to identify this obvious mass rises to the level of gross negligence as well as incompetence.

PATIENT B

Factual Allegations B and B.1: SUSTAINED

Dr. Wolf stated that image number 35 along with others clearly shows ascitic fluid around the patient's liver. (T. 72-73) The resident, Dr. Bhandarkar found the ascites but when she discussed it with Respondent, he disagreed. The report had to be amended to include this finding the following day. (Pet. Ex. 11, T. 220-221) Dr. Wolf considered this a severe deviation from the standard of care because the ascites is easily seen and it could be of great significance to the patient. (T. 69) She further noted that it is not necessary to refer to a prior study to diagnose ascites. (T. 81)

Even Dr. Cohen noted that "Bowel is seen in front of the liver to obscure perhaps a little bit of a pick up of the ascites, but it's still there." (T. 814) On cross examination, Dr. Cohen stated that "abnormal ascites is abnormal" and with or without a knowledge of a prior study, it should be picked up. (T. 821-822) The Hearing Committee concurs and

finds this to rise to the level of gross negligence. The Hearing Committee further finds incompetence by Respondent because even after the resident brought this information to his attention, Respondent failed to differentiate the difference between fat and fluid.

PATIENT C

Factual Allegations C and C.1: SUSTAINED

Respondent's report concluded that there was no radiologic evidence of diverticulitis in Patient C.(Pet. Ex.12) Dr. Wolf however opined that this was a deviation from the standard of care to say there is no evidence of diverticulitis because the colon is very thickened and there's infiltration around it. (T. 84-85) She further explained that she would favor a diagnosis of diverticulitis involving adnexa rather than two diagnoses or just tubo-ovarian abscess. Dr. Cohen, when asked if he would rule out diverticulitis, replied that there "is absolutely GI or GYN pathology here," but "this is not classic diverticulitis." (T. 845) At the hearing Respondent acknowledged that in retrospect diverticulitis is a better diagnosis. He stated that what he was trying to say in his report was is that there was no evidence of "acute diverticulitis" (T. 645). The Hearing Committee does not accept Respondent's explanation that he meant to say it differently in his report as justification for his omission. The Hearing Committee finds that Respondent's conclusion of no diverticulitis and failure to include the differential diagnosis amounts to negligence and incompetence in this instance.

PATIENT D

Factual Allegations D, D.1 and D.2 : SUSTAINED

Dr. Wolf testified that Respondent's CT report for this patient does not accurately interpret the CT. The first and second paragraphs state that there is no suspicious mesenteric abnormality. Compressed mesenteric vessels are present. There is infiltration in the mesenteric in the right lower quadrant. (T. 108-109) This is a serious departure because there is obvious abnormality in the right lower quadrant of the abdomen. (T.111) Dr. Wolf further testified that the next part of the report up to the addendum also does not accurately interpret the CT because it fails to mention appendicitis as a possibility. (T.109) She noted that there is a sense of infiltration starting at image 64 to 72 in the mesentery in the right lower quadrant. (T.112) Dr. Wolf disagreed with Respondent's explanation that an overly extended bladder caused a misinterpretation of the scan. Dr. Wolf also found Respondent's failure to identify a sacral lesion as a moderate deviation because it is relatively easy to miss bone lesions on a CT scan for other reasons. (T. 117)

While Dr. Cohen did not see a definitive appendix in the scan, he admitted he would have called the right lower quadrant with a little bit more aggression. (T. 862) He also acknowledged that given the limited history and the findings of right lower quadrant pathology, you statistically cannot exclude appendicitis. (T.866) The Hearing Committee concurs with Dr. Wolf and finds that Respondent's failure to identify Patient D's appendicitis rises to the level of gross negligence and Respondent's failure to identify the sacral lesion constitutes negligence.

PATIENT E

Factual Allegations E and E.1: SUSTAINED

Dr. Wolf stated it was a moderate deviation for Respondent to fail to note the soft tissue mass in the right lower quadrant in his report because it was suspicious for a mass in the cecum, which could be cancer. She noted that it can be seen in images 64 through 72 . (Pet. Ex.8, 14, T. 134-137) Even Dr. Cohen stated that he would have said there is "soft tissue density. I don't know what it is." (T. 877) Respondent testified that he believed the mass was fecal matter but he was instructed by Dr. Fleishaker to add an addendum on the report that there was concern for a cecal mass. (T. 719-720)

The Hearing Committee finds that Respondent was negligent as well as incompetent for his failure to mention the diagnosis with the greatest severity and then give a differential diagnosis.

PATIENT F

Factual Allegations F. and F.1: SUSTAINED

Dr. Wolf opined that Respondent's failure to identify a closed loop bowel obstruction was a serious deviation from the standard of care. (T. 148-150) Respondent's attempts to defend his statement in his report that "there is no evidence for bowel obstruction" was not persuasive to the Hearing Committee. (T.752-764) Even Dr. Cohen acknowledged that this is not "a good sentence" when questioned about Respondent's report. (T. 893) As a result, the Hearing Committee finds that Respondent's misconduct rises to the level of gross negligence as well as incompetence.

In conclusion, the Hearing Committee sustains the First Specification for negligence on more than one occasion, the Second through Fifth Specifications for gross negligence and the Sixth Specification for incompetence on more than one occasion.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above determined by a unanimous vote that Respondent's license to practice medicine in New York State should be suspended for a period of three (3) years following the effective date of this Determination and Order. The suspension shall be stayed in its entirety and Respondent will be placed on probation with a specific requirements for retraining which is subject to supervision by the Office of Professional Medical Conduct. The complete terms of probation are attached to this Determination and Order as Appendix II. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension and/or probation, censure and reprimand, the imposition of monetary penalties and dismissal in the interests of justice.

The Hearing Committee voted for a stayed suspension with probation and retraining because while they believe that Respondent's general radiology skills are adequate, the record shows that he has difficulty reading CAT scans. Retraining under the supervision of OPMC, followed by a two (2) year probation is the best way to safeguard the public against future missed CAT scan readings by the Respondent. Under

the totality of the circumstances, the Hearing Committee concludes that this penalty is commensurate with the level and nature of Respondent's professional misconduct.

ORDER

Based upon the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The First through Sixth Specifications of Professional Misconduct, as set forth in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. Respondent's license to practice medicine in New York State be and hereby is **SUSPENDED** for a period of **THREE (3) YEARS,** said suspension to be **STAYED**; and

3. Respondent shall complete a course of **RETRAINING** as set forth in Appendix II;

4. Respondent's license shall be placed on **PROBATION** during the period of suspension, and he shall comply with all Terms of Probation as set forth in Appendix II, attached hereto and made a part of this Order; and

5. This Order shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

DATED: New York, New York

July 30, 2008

Redacted Signature

CALVIN J. SIMMONS, M.D.
(Chairperson)

MANGALA RAJAN, M.D.
RANDOLPH H. MANNING, Ph.D

TO: Paul Stein, Esq.
Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street - 4th Fl
New York, NY 10007

Daniel J. Hurteau, Esq.
Nixon Peabody LLP
Omni Plaza
30 South Pearl Street
Albany, N.Y. 12207-3425

Sheldon Wieder. M.D.

Redacted Address

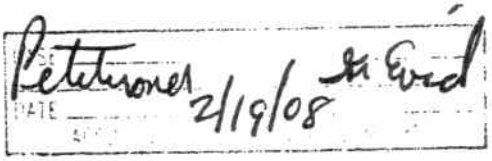
APPENDIX I

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

IN THE MATTER OF SHELDON LEWIS WIEDER, M.D.	NOTICE OF HEARING

TO: SHELDON LEWIS WIEDER, M.D.

Redacted Address



PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on February 27, 2008, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, NY 10007, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents, and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF

ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law §230(10)(c), you shall file a written answer to each of the charges and allegations in the Statement of Charges not less than ten days prior to the date of the hearing. Any charge or allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to §301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person. Pursuant to the terms of N.Y. State Admin. Proc. Act §401 and 10 N.Y.C.R.R. §51.8(b), the Petitioner hereby demands disclosure of the evidence that the Respondent intends to introduce at the hearing, including the names of witnesses, a list of and copies of documentary evidence and a description of physical or other evidence which cannot be photocopied.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

THESE PROCEEDINGS MAY RESULT IN A

DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW §§230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York
January 25, 2008

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Paul Stein
Associate Counsel
Bureau of Professional Medical Conduct
New York State Department of Health
90 Church Street, 4th Floor
New York, NY 10007
(212) 417-4450

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

IN THE MATTER

OF

SHELDON LEWIS WIEDER, M.D.

STATEMENT

OF

CHARGES

SHELDON LEWIS WIEDER, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 22, 1968, by the issuance of license number 101867 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about July 24, 2003 and May 24, 2004, the Respondent, a radiologist, interpreted CT scans of the abdomen, pelvis and chest of Patient A at the New York University Medical Center, New York, New York. On or about May 24, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient A that had been performed for the clinical indication of "lower abdominal pain, evaluate for aortic dissection." Priya Bhandarkar, M.D., a resident who preliminarily evaluated the CT scan, informed Respondent that, in her opinion, the film revealed an exophytic mass in the right kidney.

1. Respondent deviated from medically accepted standards in that he interpreted Patient A's kidneys as "normal".

B. On or about May 24, 2004, the Respondent evaluated a CT scan of the chest of Patient B that had been performed for the clinical indication of pulmonary emobolus. Priya Bhandarkar, M.D., a resident who preliminarily evaluated the CT scan, informed Respondent that in her opinion the film

revealed ascites in the upper abdomen.

1. Respondent deviated from medically accepted standards in that he concluded that the images of the upper abdomen of Patient B were "unremarkable".

C. On or about February 15, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient C for the clinical indication of lower abdominal pain and a history of diverticulitis and tubo-ovarian abscess.

1. Respondent deviated from medically accepted standards in that he concluded that there was no radiologic evidence of diverticulitis in Patient C.

D. On or about February 4, 2004, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient D that had been performed for the clinical indication of abdominal pain.

1. Respondent deviated from medically accepted standards in that he failed to identify an abnormality in the right lower quadrant of Patient D, most likely appendicitis.
2. Respondent deviated from medically accepted standards in that he failed to identify a sacral lesion in Patient D.

E. On or about September 14, 2003, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient E that had been performed for the clinical indication of lower abdominal pain.

1. Respondent deviated from medically accepted standards in that he failed to identify a soft tissue mass in the right lower quadrant of the abdomen of Patient E.

F. On or about July 24, 2003, the Respondent evaluated a CT scan of the abdomen and pelvis of Patient F for the clinical indication of acute periumbilical pain, nausea and vomiting. Patient F also had an elevated white count.

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

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(3) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1; B and B1; C and C1; D and D1-2; E and E1; and/or F and F1.

SECOND THROUGH FIFTH SPECIFICATIONS
GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(4) by practicing the profession of medicine with gross negligence on a particular occasion as alleged in the facts of the following:

2. Paragraphs A and A1.

3. Paragraphs B and B1.

4. Paragraphs D and D1-2.

5. Paragraphs F and F1.

SIXTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(5) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

6. Paragraphs A and A1; B and B1; C and C1; D and D1-2; E and E1; and/or F and F1.

DATE: New York, New York
January 25, 2008

Redacted Signature

ROY NEMERSON
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX II

Standard Terms of Probation

1. Respondent shall conduct himself/herself in all ways in a manner befitting his/her professional status, and shall conform fully to the moral and professional standards of conduct and obligations imposed by law and by his/her profession.

2. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River Street, Suite 303, Troy, New York 12180-2299, said notice is to include a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions or disciplinary actions by any local, state or federal agency, institution or facility, within thirty days of each action.

3. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC as requested by the Director.

4. Any civil penalty not paid by the date prescribed herein shall be subject to all provisions of law relating to debt collection by New York State. This includes but is not limited to the imposition of interest, late payment charges and collection fees; referral to the New York State Department of Taxation and Finance for collection; and non-renewal of permits of licenses {Tax Law Section 171(27)}; State Finance Law section 18; CPLR section 5001; Executive Law section 32}.

5. The period of probation shall be tolled during periods in which Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC, in writing, if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation which were not fulfilled shall be fulfilled upon Respondent's return to practice in New York State.

6. Respondent's professional performance may be reviewed by the Director of OPMC. This review may include, but shall not be limited to, a review of office records, patient records and/or hospital charts, interviews with or periodic visits with Respondent and his/her staff at practice locations or OPMC offices.

7. Respondent shall maintain legible and complete medical records which accurately reflect the evaluation and treatment of patients. The medical records shall contain

all information required by State rules and regulations regarding controlled substances.

Retraining

8. Respondent shall obtain a clinical competency assessment performed by a program for such assessment as directed by the Director of OPMC. Respondent shall cause a written report of such assessment to be provided directly to the Director of OPMC within sixty (60) days of the effective date of this Order.

9. Respondent shall be responsible for all expenses related to the clinical competency assessment and shall provide to the Director of OPMC proof of full payment of all costs that may be charged. This term of probation shall not be satisfied in the absence of actual receipt, by the Director, of such documentation, and any failure to satisfy shall provide a basis for a Violation of Probation proceeding.

10. At the direction of the Board and within sixty 60 days following the completion of the clinical competency assessment (CCA) the Respondent shall identify a Preceptor, preferably a physician who is board certified in the same specialty, to be approved in writing, by the Director of OPMC.

    The Respondent shall cause the Preceptor to:

    a. Develop and submit to the Director of OPMC for written approval a remediation plan, which addresses the deficiencies/retraining recommendations identified in the CCA. Additionally, this proposal shall establish a time frame for completion of the remediation program of not less than three (3) months and no longer than twelve (12) months.

    b. Submit progress reports at periods identified by OPMC certifying whether the Respondent is fully participating in the personalized continuing medical education program and is making satisfactory progress towards the completion of the approved remediation plan.

    c. Report immediately to the Director of OPMC if the Respondent withdraws from the program and report promptly to OPMC any significant pattern of non-compliance by the Respondent.

    d. At the conclusion of the program, submit to the Director of OPMC a detailed assessment of the progress made by the Respondent toward remediation of all identified deficiencies.

11. Respondent shall practice medicine in either private practice, hospitals or other

institutional settings outside of the personalized continuing medical education program, only when monitored by a licensed physician, board certified in an appropriate speciality (practice monitor), proposed by Respondent and subject to the written approval of the Director of OPMC.

a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the practice monitor, including on-side observation. The practice monitor shall visit Respondent's medical practice at each and every location, on a random unannounced basis at least monthly and shall examine a selection (no less than 10) of records maintained by Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

b. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

12. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy years, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

13. For a period of two years, to commence immediately following the completion of the approved personalized continuing medical education program, Respondent shall practice medicine only when monitored by a physician, board certified in an appropriate specialty (practice monitor), proposed by Respondent and subject to the written approval of the Director of OPMC. The Respondent shall cause the practice monitor to monitor Respondent's medical practice in accordance with a monitoring plan to be approved by the Director of OPMC. Such monitoring plan shall include, but not be limited to, provisions for selected medical record reviews, occasional observation of the Respondent in practice settings, required participation in hospital departmental meetings and enrollment in ongoing education courses, if any.

14. Respondent shall cause the practice monitor to report to OPMC on a quarterly basis regarding Respondent's compliance with the approved monitoring plan. These narrative reports shall address all aspects of Respondent's clinical practice including, but not limited to, the evaluation and treatment of patients, the monitor's assessment of patient records selected for review, detailed case description of any case found to not meet the established standards of care and Respondent's remediation of previously identified deficiency areas.

15. Respondent shall enroll in and complete a continuing medical education program in the areas of body imaging/cat scan/abdomen and pelvis to be equivalent to at least 100 credit hours of Continuing Medical Education for each year for which he is on probation. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the period of probation or as otherwise specified in the Order.

16. Respondent shall be solely responsible for all expenses associated with these terms, including fees, if any, for the clinical competency assessment, the personalized continuing medical education program or to the monitoring physician.

17. Respondent shall comply with all terms, conditions, restrictions, limitations and penalties to which he or she is subject pursuant to the Order and shall assume and bear all costs related to compliance. Upon receipt of evidence of noncompliance with, or any violation of these terms, the Director of OPMC and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized pursuant to the law.