Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

June 8, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Donn Wiedershine, M.D.
REDACTED

Daniel J. Hurteau, Esq.
NIXON PEABODY, LLP
677 Broadway – 10th Floor
Albany, New York 12207

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

RE: In the Matter of Donn Wiedershine, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-97) 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.

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 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.

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 licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

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

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah
Enclosure

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

COPY

IN THE MATTER

OF

DONN WIEDERSHINE, MD

DETERMINATION

AND

ORDER

BPMC #10-97

A Notice of Hearing, and Amended Statement of Charges both dated April 16, 2008 were served upon the Respondent **DONN WIEDERSHINE, M.D.** Chairperson **DAVID HARRIS M.D., PRADEEP CHANDRA M.D.,** and **DONALD KELLY duly** designated members of the State Board of Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN ESQ**. served as the Administrative Officer.

The Department of Health appeared by THOMAS CONWAY ESQ., General Counsel, by **NANCY STROHMEYER**, of Counsel. The Respondent **DONN WIEDERSHINE, M.D.** appeared in person and by Counsel **DANIEL J. HURTEAU ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made.

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

PROCEDURAL HISTORY

Notice of Hearing & Amended Statement of Charges	April 3, 2008 & April 16, 2008
Respondent's Answer	January 8, 2010

Hearing Dates	January 19, 2010, February 4, 2010
Witnesses for Petitioner	Allen Fein M.D., Lawrence Severino M.D.
Witnesses for Respondent	Arthur N. Gertler M.D. Donn Wiedershine M.D.
Final Hearing Transcript Received	February 19, 2010
Parties Briefs	March 5, 2010
Deliberations Date	April 9, 2010

STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Donn Wiedershine M.D. (hereinafter "Respondent") is charged with five specifications of misconduct including: negligence on more than one occasion, incompetence on more than one occasion, gross negligence, gross incompetence, and failing to maintain patient records as set forth in Section 6530 of the Education Law of the State of New York (hereinafter Education Law). The Respondent denies the First through the Fifth Specifications set forth in the Amended Statement of Charges. The Respondent alleges, "his treatment of Patient A, on or about February 9, 2007 and between February 15, 2007 was appropriate (Ex. A). The Respondent requests that all factual allegations regarding Patient A and five specifications of misconduct set forth in the Notice of Hearing and Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix 1, be dismissed in their entirety.

FINDING OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("Tr."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard argument and considered the documentary evidence presented, the Hearing Committee hereby makes the following finding of fact:

1. On or about June 24, 1986, Donn Wiedershine M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number 166433 (Ex. 2).
2. The Respondent treated Patient A at his office in Woodstock New York, and at Patient A's home (Ex. 3, 3a)
3. During Respondent's treatment of Patient A from on or about February 9, 2007 through February 15, 2007, Respondent inappropriately administered intravenous hydration to Patient A and failed to: obtain adequate medical history, perform adequate physical examinations, order appropriate diagnostic tests to follow up on finding that the patient had enlarged lymph nodes, appropriately assess and treat patient complaints of constipation, and maintain a medical record that accurately reflects the care and treatment of Patient A (Ex. 3, 3a; Tr. 43-46, 50-54, 58-59, 65-69, 73-86, 114-116, 143-144, 168-169, 176, 459-469, 486).

CONCLUSIONS

The Hearing Committee ("Hearing Committee" or "Committee") sustained the Factual Allegations set forth in Paragraph A, A1, A3, A4, A5, A6, and the First, Third and Fifth Specifications of misconduct as set forth in the Statement of Charges (Ex.1). The Committee's

conclusions were unanimous and based on the entirety of the record. The Hearing Committee found based on a preponderance of the evidence that the Respondent's conduct constitutes negligence on more than one occasion, gross negligence, and failure to maintain a record for a patient which accurately reflects the care and treatment of the patient pursuant to Education Law Section 6530(3), (4), and (32) respectively (Ex. 1).

The Hearing Committee did not sustain the Factual Allegations in Paragraph A2 and the Second and Fourth Specifications set forth in the Statement of Charges that specifically relate to incompetence on more than one occasion and gross incompetence pursuant to Education Law Sections 6530(5)&(6) (Ex. 1). The rationale for the Committee's conclusions is set forth below.

DISCUSSION

This case involves the care and treatment Respondent provided to one patient over a period of approximately one week. Respondent was charged with violating five subdivisions of professional misconduct under Education Law Section 6530 including: negligence on more than one occasion, gross negligence, incompetence on more than one occasion, gross incompetence, and failing to maintain a patient record that accurately reflects the care and treatment provided. Education Law Section 6530 (3), 6530(4), 6530(5), 6530(6) & 6530 (32). During the course of deliberations the Committee consulted a memorandum entitled "definitions of Misconduct Under the New York Education Law," which sets for the statutory definitions of misconduct as well as an explanation of the definitions (ALJ 1A, Definitions of Professional Misconduct-Greenberg Memorandum). The following definitions were utilized by the Committee:

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

Gross Negligence is the 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 lack of the requisite skill or knowledge necessary to practice the profession.

Gross Incompetence is lack of the requisite skill or knowledge necessary to practice the profession that is significantly or seriously substandard and poses potentially grave consequences

The Hearing Committee made a credibility determination about the witnesses based on their experience, credentials and demeanor. They also determined whether the testimony provided by each witness was supported or contradicted by other evidence in the record.

The Department presented two witnesses Dr. Lawrence Severino and Dr. Allen L. Fein. Dr. Severino is a Medical Coordinator for the Office of Professional Medical Conduct and provided limited testimony about his interview with Respondent. Dr. Allen Fein a physician practicing family medicine and a board certified acupuncturist with training in holistic medicine was the Department's medical expert and chief witness (Ex. 5). The Committee found both Department witnesses to be credible.

The Respondent testified on his own behalf and presented medical expert Dr. Arthur N. Gertler. The Respondent is a physician who treats patients interested in alternative and holistic medicine and described his practice as integrating traditional and alternative medicine with psychiatry (Tr. 228- 232). Dr. Gertler a board certified internist and gastroenterologist with training in holistic medicine provided limited testimony about Respondent's care and treatment of the patient's constipation and impaction during a home visit on February 15, 2007 (Ex. C). The Committee found both the Respondent and Dr. Gertler to be credible, however,

Respondent's testimony appeared for the most part to be self serving as he attempted to fill in the blanks in the patient record and account for lapses and deficiencies in the care he provided to Patient A. It was obvious to the Committee that Dr. Gertler is a knowledgeable and experienced physician, for this reason they could not ignore his limited and decidedly tepid support of Respondent's care and treatment of Patient A.

Office Visits

Respondent testified that Patient A was interested in being treated by a physician with a holistic medical approach and referred to him by the patient's dentist. Respondent saw Patient A on four occasions over a period of about a week (Ex. 3, 3a). During Patient A's first appointment Respondent spent an hour or more with the patient "gathering information" (Tr.234, 247). The patient's chief complaint was "not feeling well", and among other things the patient also complained of a headache and feeling anxious (Ex. 3 p. 2). Respondent believed that the patient's anxiety was contributing to her physical symptoms (Tr. 233, 234, 246). During the initial visit, Respondent noted in the patient record that upon physical examination he found the patient had enlarged lymph nodes in the groin and armpit and indicated the finding was serious and required the patient to undergo diagnostic testing, evaluation and follow up within "a few days" after he reduced the patient's anxiety "with stress reduction therapy" (Ex. 3 p. 2, 4). After the initial visit the Respondent did not follow up or evaluate the finding of enlarged lymph nodes.

During the second office visit on February 12, 2007, the patient complained of feeling anxious and having a headache. Respondent noted in the patient record that he prescribed dietary changes for possible hypoglycemia, "thioctic acid to prevent and treat migraines," and "push fluids" (Ex. 3 p.5). Respondent administered intravenous ("IV") fluids to the patient

noting the patient's urine had a "high sp. gravity (1.025)," and he provided stress reduction therapy (Ex.3 p.5). The Respondent did not indicate in the patient record what stress reduction therapy he provided and whether it was effective, and what or how much IV fluid he administered.

During the third office visit On February 13, 2007, the patient again complained of feeling anxious. The note in the record indicates that the Respondent provided stress reduction therapy (Ex. 3 p. 5). Again there is no description of the stress reduction therapy Respondent provided to the patient or whether it was effective.

The Department's expert Dr. Fein testified that during the office visits Respondent failed to obtain an adequate medical history including medications, diet, and/ or allergies; order appropriate diagnostic testing; adequately diagnose a condition or establish a treatment plan. During the first visit Dr. Fein found that it was a deviation from acceptable standards of care not to get a full medical history and while Respondent noted that the patient had enlarged lymph nodes and this finding required immediate follow up and diagnostic testing, Respondent did not address this finding again. Dr. Fein stated that enlarged lymph nodes generally indicate a serious medical condition such as cancer (Tr. 50-54).

During the second office visit Respondent prescribed "thioctic acid" for migraines, while Dr. Fein thought that was acceptable, he testified that Respondent inappropriately administered IV fluids based on an incorrect reading and reliance on a urinalysis specific gravity number and this patient's complaints of dehydration. Respondent did not note any clinical signs or symptoms of dehydration and Dr. Fein concluded that there was nothing in the record to justify administration of IV fluids, and the appropriate treatment for the patient's complaint of dehydration would have been to give the patient a few glasses of water (Tr. Ex 3a; Tr. 43-46, 66-

69). Finally, Dr. Fein testified that Respondent's failure to document what and how much IV fluid he administered to the patient was also an unacceptable deviation from the standard of care (Tr. 176).

Dr. Fein observed that the Respondent repeatedly documented that the patient was anxious, and while Respondent treated the patient for anxiety he did not explore the history or underlying causes of the patient's anxiety (Tr. 45, 143). During the second and third visit Respondent indicated that he treated the patient's anxiety with stress reduction therapy, however, he did not specify what treatment was provided and whether it was effective (145-146).

Dr. Fein concluded that during the three office visits Respondent repeatedly deviated from acceptable standards of medical care including that he inappropriately administered intravenous hydration to Patient A and failed to: obtain adequate medical history, perform adequate physical examinations, order appropriate diagnostic tests to follow up on finding that the patient had enlarged lymph nodes, and maintain a medical record that accurately reflects the care and treatment of Patient A. Dr Fein's testimony about Respondent's numerous deviations from acceptable standards of care and treatment of Patient A during the office visits was unchallenged by the Respondent's expert.

Home Visit

On or about February 15, 2007, Respondent provided care to Patient A at the patient's home. The patient called the office complaining of abdominal pain and the patient was seeking Respondent's opinion about the patient calling an ambulance (Tr. 268). Respondent testified that there had been a big snowstorm the day before and travel was difficult so he visited Patient A at home, it took approximately fifty minutes to get there (Tr. 272). When

Respondent arrived the patient was on the floor in the kitchen, he took a history and performed a physical, and diagnosed and treated the patient for constipation (Tr. 271-274). After spending several hours with the patient and providing treatment including: enema, citrate of magnesia, and digital/manual disimpaction he found that the treatments were not successful in relieving the patient's discomfort (Ex. 3, Tr. 389-393). Respondent testified that he then fashioned a disimpaction instrument by attaching with duct tape a baby spoon to a spatula handle ("improvised instrument " or "unapproved instrument") explaining that the spoon was small, smooth and made out of metal (Tr. 339-342). Respondent testified that he had never performed a disimpaction, did not tell the patient about his lack of experience, and when questioned by the Committee Chair admitted that there was no urgency to provide the treatment (Tr.338, 393). The Respondent testified that he believes the benefit of attempting the disimpaction in the comfort of the patient's home with the improvised instrument was greater than the risk to the patient (Tr. 389 - 393). After Respondent attempted to disimpact the patient using the improvised instrument he determined that the procedure did not alleviate the impaction and sent the patient to the hospital. The patient record is devoid of any information about the use and make up of the improvised instrument.

Dr. Fein testified that Respondent's initial assumption that the patient was constipated was questionable in that abdominal pain could indicate that something more urgent and serious could have been wrong with the patient and a reasonably prudent physician would have explored other diagnoses in addition to constipation (Tr. 80-86). Dr. Fein also found it unacceptable that Respondent decided to make a house call and conduct a lengthy home visit with different levels of intervention, instead of supporting the patient's own initial suggestion to call an ambulance (Tr. 84-86). Both experts agreed that assuming Respondent appropriately diagnosed

that the patient was constipated his treatment of the condition with enema, citrate of magnesia, and digital/manual disimpaction was acceptable.

Dr. Fein testified that Respondent's use of the improvised instrument was a significant and egregious deviation from accepted standards of care in that Respondent chose to perform the procedure absent any urgent need in a non –clinical setting, with a rigid untested instrument and without the ability to visualize the proper insertion of the instrument into the rectum thereby presenting serious risk of perforating the patient's bowel (Tr. 93-96).

Dr. Gertler testified that the use of the improvised instrument deviated from "normal practices", however, he said Respondent's use of the instrument was acceptable (Tr. 459- 460). The Committee found it telling that Dr. Gertler took the opportunity to state that he himself would not have attempted to disimpact Patient A with the improvised instrument and in this case there would be no harm in waiting to attempt to disimpact the patient in a clinical setting with the benefit of assistance and instruments approved for visualization and disimpaction (Tr. 459-469, 486).

Based on the self evident deficiencies in the patient record and Dr. Fein's testimony about Respondent's repeated and serious deviations from acceptable standard of care combined with Dr. Gertler's limited support of the care Respondent provided to Patient A, the Committee concluded that the Respondent is guilty of negligence on more than one occasion, gross negligence, and failure to maintain medical records that accurately reflect the care and treatment of a patient (See Ex. ALJ 1A, Definitions of Professional Misconduct-Greenberg Memorandum," Education Law Section 6530 (3),6530(4) & 6530 (32)).

In order to sustain the allegations of incompetence and /or gross incompetence the Hearing Committee would be required to find that the Respondent lacks the requisite skill or

knowledge necessary to practice the profession (See Ex. ALJ 1A, Education Law Section 6530(5) & 6530(6)). The Hearing Committee concluded that in some instances Respondent did adequately treat Patient A, including the facts in paragraph A2 where it was determined that Respondent appropriately assessed and treated Patient A's migraine headaches. The Hearing Committee concluded that there is insufficient credible evidence that the Respondent was incapable of meeting accepted professional medical standards, and thus could not sustain the allegations of incompetence and/or gross incompetence.

DETERMINATION AS TO PENALTY

The Hearing Committee determined that while Respondent has a holistic / alternative approach to medicine he is indeed practicing medicine, and in this case he lost sight of his obligation to adhere to accepted standards of care. Upon concluding that the Respondent is guilty of three specifications of professional misconduct, and after due and careful consideration of the penalties available pursuant to Public Health Law Section 230-a, the Hearing Committee has determined that in order to protect the public the Respondent's medical license shall be suspended for three months and he shall not resume practice until he completes an approved record keeping program, and upon resuming his practice he shall have an approved practice monitor in place who will perform a monthly review of Respondent's clinical practice and a review of a random sample of his patient records for a period of one year. The specific terms of probation are attached and made part of this Determination and Order and marked as Appendix B.

ORDER

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

1. The Hearing Committee sustained the Factual Allegations set forth in Paragraph Allegations set forth in Paragraph A, A1, A3, A4, A5, A6, A7 and the First, Third and Fifth Specifications of misconduct as set forth in the Statement of Charges (Ex.1) are **SUSTAINED;**

2. The Factual Allegations in Paragraph A2 and the Second and Fourth Specifications set forth in the Amended Statement of Charges (Ex. 1) are **NOT SUSTAINED;**

3. The Respondent's license to practice medicine in New York State is hereby actually **SUSPENDED** for a period of three months. The Respondent shall not resume practice until he successfully completes a record keeping course approved by the Board of Professional Medical Conduct ("Board ") and shall be on probation for a period of three years. The first year of the three-year probationary period the Respondent shall have a Board approved practice monitor (Appendix B).

4. This **ORDER** shall be effective upon service on the Respondent pursuant to Public Health Law Section 230(10)(h).

Cold Spring Harbor, New York
DATED: June 7, 2010

REDACTED
BY: _____
DAVID HARRIS M.D., Chairperson
PRADEEP CHANDRA M.D.
DONALD KELLY

To: Donn Wiedershine. M.D.

REDACTED

Daniel J. Hurteau, Esq.
NIXON PEABODY, LLP
677 Broadway 10TH Floor
Albany, New York 12207

Nancy Strohmeyer, Esq.
NYSDOH -Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007

APPENDIX I

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

IN THE MATTER

OF

DONN WIEDERSHINE, M.D.

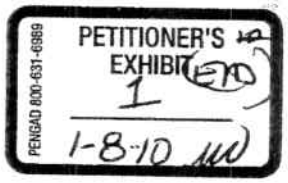
NOTICE

OF

HEARING

TO: Donn Wiedershine, M.D.

REDACTED



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 January 19, 2010, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 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 who shall be an attorney admitted to practice in New York state. 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.

YOU ARE HEREBY ADVISED THAT THE ATTACHED CHARGES WILL BE MADE PUBLIC FIVE BUSINESS DAYS AFTER THEY ARE SERVED.

Department attorney: Initial here

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. JAMES HORAN, ACTING 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
December 14, 2009

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Nancy Strohmeyer
Assistant Counsel
Bureau of Professional Medical Conduct
90 Church Street, 4th floor
New York, New York 10007
(212) 417-4346

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

IN THE MATTER

OF

DONN WIEDERSHINE, M.D.

STATEMENT

OF

CHARGES

DONN WIEDERSHINE, M.D., the Respondent, was authorized to practice medicine in New York State on or about June 24, 1986, by the issuance of license number 166433 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about and between February 9, 2007, and February 15, 2007, Respondent treated Patient A, a 62 year-old woman, at his office in Woodstock, New York, and at Patient A's home. Respondent's care of Patient A deviated from minimally acceptable standards of medical care in that:

1. Respondent inappropriately administered intravenous hydration to Patient A.
2. Respondent failed to appropriately assess and treat Patient A for migraine headaches.
3. Respondent failed to order appropriate diagnostic tests to follow up on Patient A's enlarged lymph nodes.
4. Respondent failed to appropriately assess and treat Patient A's complaints of constipation.
5. Respondent failed to obtain an adequate medical history concerning Patient A.
6. Respondent failed to perform adequate physical examinations

of Patient A.

7. Respondent failed to maintain a record which accurately reflected the care and treatment of Patient A.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

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:

1. Paragraphs A and its subparagraphs.

SECOND SPECIFICATION

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(6) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

2. Paragraphs A and its subparagraphs.

THIRD 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:

3. Paragraph A and its subparagraphs.

FOURTH 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:

4. Paragraph A and its subparagraphs.

FIFTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(32) by failing to maintain a record for each patient which accurately reflects the care and treatment of the patient, as alleged in the facts of:

5. Paragraphs A and A7.

DATE: December 14, 2009
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX B
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 or licenses [Tax Law section 171(27)]; State Finance Law section 18; CPLR section 5001; Executive Law section 32].

5. The Respondent's license to practice medicine shall be actually suspended for a period of period three months and Respondent shall be on probation for a period of three years. The three-year 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 that accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

8. Respondent shall enroll in and successfully complete a continuing education program in the area of record keeping. Said continuing education program shall be subject to the prior written approval of the Director of OPMC and be completed within the three-month period of actual suspension. Respondent shall not resume his practice until he successfully completes the record-keeping course.

9. Within thirty (30) days of the effective date of the probation, Respondent shall practice medicine only when monitored by a licensed physician specializing in family/ internal medicine ("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 monitor, including on-site clinical observation. The practice monitor shall be in place for one year from when the Respondent resumes the practice of medicine (this period shall toll when and if the Respondent is not practicing)

    b. 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 one dozen) 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.

    c. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

    d. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC and shall submit no less than four (reports).

10. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, 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

11. 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.