Public

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 27, 2012

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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

William L. Wood, Esq.
Wood & Scher
222 Bloomingdale Road
White Plains, New York 10605

Rohan Wijetilaka
REDACTED

RE: In the Matter of Rohan Wijetilaka, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 12-130) 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., Chief Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Riverview Center
150 Broadway – Suite 510
Albany, New York 12204

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
Chief Administrative Law Judge
Bureau of Adjudication

JFH:cah
Enclosure

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

IN THE MATTER OF ROHAN WIJETILAKA, M.D.	DETERMINATION AND ORDER BPMC 12-130

A Notice of Hearing and Statement of Charges, dated November 10, 2011, were served upon the Respondent Rojan Wijetilaka, M.D. The Statement of Charges was amended on December 15, 2011. **MICHAEL R. GOLDING, M.D.**, Chairperson, **REID T. MULLER, M.D.** and **JOAN MARTINEZ-McNICHOLAS**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **WILLIAM J. LYNCH, ADMINISTRATIVE LAW JUDGE**, served as the Administrative Officer.

The Department of Health ("the Department") appeared by **JAMES E. DERING**, General Counsel, by **CHRISTINE M. RADMAN, ESQ.**, of Counsel. The Respondent appeared by Wood & Scher, **WILLIAM L. WOOD, ESQ.**, of Counsel. Evidence was received, witnesses sworn and heard, and transcripts of the proceedings were made.

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

PROCEDURAL HISTORY

Pre-Hearing Conference: December 5, 2011

Hearing Dates:	December 15, 2011 January 24, 2012 January 31, 2012 February 9, 2012 February 28, 2012 March 15, 2012
Witnesses for Petitioner:	Steven R. Bergmann, M.D., Ph.D.
Witnesses for Respondent:	Rohan Wijetilaka, M.D. Robert M. Siegel, M.D.
1. Written Submissions Received:	April 23, 2012
Deliberations Held:	May 3, 2012

STATEMENT OF CASE

The State Board for Professional Misconduct is a duly authorized professional disciplinary agency of the State of New York (§230 et seq of the Public Health Law of the State of New York [hereinafter "P.H.L."]).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to §230 of the P.H.L. Rohan Wijetilaka, M.D. ("Respondent") is charged with forty-one specifications of professional misconduct, as defined in §6350 of the Education Law of the State of New York ("Education Law"). The charges include allegations of Respondent having committed professional misconduct due to gross negligence, negligence on more than one occasion, incompetence on more than one occasion, ordering unwarranted tests, fraudulent practice, filing false reports, and failing to maintain adequate medical records. A copy of the Notice of Hearing and Amended Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS 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 ("T."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Having heard testimony and considered documentary evidence presented by the Petitioner and Respondent, respectively, the Hearing Committee hereby makes the following findings of fact:

1. Respondent, Rohan Wijetilaka, M.D., was authorized to practice medicine in New York State on or about August 30, 1993, by the issuance of license number 193531 by the New York State Education Department. (Dept Ex. 2).

Patient A

2. During the period between on or about April 9, 1999 through January 16, 2003, Respondent was Patient A's cardiologist. The broad field of cardiology involves the evaluation and treatment of heart and vascular disease. (Dept. Ex. 3A, 3B and 3C; T. 19-20).

3. Patient A was 56-year-old man when he visited Respondent's office on April 9, 1999 complaining of shortness of breath, eighteen days after having had quintuple coronary artery bypass surgery. His other pertinent medical history included a finding of an abdominal aortic aneurysm ("Triple A"), angina, hypertension, hypercholesterolemia and chronic obstructive pulmonary disease with a two pack a day smoking habit for many years. Respondent deviated from the standard of care by not performing an adequate history and physical ("H&P") and inadequately performing a differential diagnosis for Patient A in order to direct an efficacious treatment plan. He failed to describe the nature,

duration and precipitating/ameliorating events for the shortness of breath; failed to record the date and nature of the bypass surgery; failed to check the condition of the coronary artery bypass surgical scar; failed to check the patient's pulse, respiratory rate, oxygen saturation level and temperature; failed to get blood work to rule out post-operative bleeding and/or anemia; failed to order a chest x-ray to rule out pericardial or pleural effusions; failed to refer the patient to a pulmonologist to further investigate the cause(s) of the shortness of breath; failed to institute a treatment plan for the shortness of breath; and failed to address when and how Patient A's Triple A was to be evaluated. (Dept. Ex. 3A, pp. 8-10, 74-77, 88-89; T. 110-117, 187-188).

4. Patient A visited Respondent's office eleven days later, on April 20, 1999, again complaining of shortness of breath which again went unevaluated and untreated. (Dept. Ex. 3A, p. 10; T. 121-123).

5. Patient A visited Respondent's office fifteen times over three and a half years, from April 1999 through November 2002, complaining at least ten times of shortness of breath. Respondent deviated from the standard of care in that this symptom was never adequately evaluated or treated. (Dept. Ex. 3A, pp. 10-17; T. 117-119).

6. Respondent recorded Patient A's blood pressures consistently as 130/80 over nine separate visits from July 27, 1999 through April 22, 2002. This is physiologically unlikely. It is critically important in the care of patients with an aortic abdominal aneurysm to ensure that blood pressure is well controlled and kept as low as tolerable. Respondent's failure to obtain an accurate and true blood pressure measurement on each of the nine separate visits is a deviation from the standard of care. (Dept. Ex. 3A, pp. 11-15; T. 119-120, 125-127).

7. Respondent did not record a pulse rate for Patient A during the clinical examination at any of the fifteen documented visits to his office. A cardiac patient's pulse must be taken during a physical examination, especially when a patient is on beta blockers, as was Patient A, because such medication

can cause electrical abnormalities (affecting the pulse rate). In failing to do so, Respondent deviated from the standard of care. (Dept. Ex. 3A, pp. 10-17; T. 115).

8. Respondent prescribed Meridia, a weight loss medication, for Patient A on November 2, 1999, when the patient's weight increased from 177 to 199 pounds over seven months. A reasonably prudent physician, given this patient's history, would need to rule out heart failure as the cause of the weight gain. Respondent did not. In addition, the medication he prescribed to Patient A is contraindicated in patients with both coronary artery disease and an abdominal aneurysm, because it stimulates the adrenergic system which could raise the blood pressure and give the patient tachycardia. (Dept. Ex. 3A, p. 11; T. 129-131).

9. Also at the November 2, 1999 office visit, Respondent provided no evaluation for Patient A's complaint of dizziness. At the very least, Respondent should have checked Patient A's vital signs including blood pressure, both lying down and standing, and ordered blood work to rule out anemia or any other metabolic abnormalities, to comport with the standard of care. (Dept. Ex. 3A, p. 11; T. 131-132).

10. In early 1996, a CT scan of Patient A's lumbar spine revealed a focal widening of his abdominal aorta measuring 2.4 centimeters. This is documented in Patient A's first visit to Respondent's office in 1999. An abdominal aortic aneurysm is a ballooning or widening/enlarging of a blood vessel, typically labeled so at 3 centimeters, that may dissect or tear into the interior walls of the vessel and/or perforate or rupture through all of the walls so there is bleeding from the blood vessel. The complete rupture of an aortic aneurysm is a catastrophic event. An aortic ultrasound taken three years later, on January 16, 1999, revealed that Patient A's abdominal aortic widening grew to 3.74 centimeters. This is documented in Patient A's first visit to the Respondent's office in 1999. The rate of growth from 2.4 centimeters in early 1996 to 3.74 centimeters just three years later is atypical, requiring frequent

assessment, both clinically and with ultrasound, at least yearly. Respondent deviated from the standard of care by failing to perform this non-invasive, relatively short ultrasound procedure. (Dept. Ex. 3A, p. 8, 127; T. 119-120, 138-143, 205-206, 780-781).

11. On February 4, 2000, Patient A returned to Respondent for a follow-up visit. At that time, Respondent discontinued Ecotrin (baby aspirin) from Patient A's medications without explanation. Aspirin is one of the basic medications used to treat heart disease and help prevent myocardial infarction. It is a deviation of the standard of care to discontinue a cardiac patient's anticoagulation regimen and fail to indicate the reason in that patient's chart. (T. 134-135).

12. Also at that visit, which was one year after Patient A's last documented aortic ultrasound measuring his Triple A, Respondent failed to perform an ultrasound to assess the current state of the aneurysm. Therefore, Respondent did not know its current size or rate of growth over the preceding year. Notwithstanding this critical lack of obtainable medical information and without any explanation in the patient's chart, he ordered and performed a nuclear stress test on Patient A on March 24, 2000 with no medical indication. In addition, there is no record of Respondent examining Patient A before stressing his heart one year, almost to the day, after his quintuple bypass surgery. The failure to assess the Triple A's size and stability, compounded by the absence of a pre-test physical examination, heighten the egregiousness of this unnecessary nuclear stress test. These are gross deviations from the standard of care. (Dept. Ex. 3A, p. 12; T. 133-137).

13. A nuclear stress/perfusion test is similar to an exercise stress test which increases the blood flow to the heart up to a maximal guideline-directed heart rate to diagnose ischemic heart disease. The injection of a nuclear isotope with imaging adds more information to the testing process which makes the results more sensitive. The test is non-diagnostic if the target heart rate cannot be achieved. In such

cases, pharmacologic agents can be used to adequately stress the heart or other measures undertaken, including cardiac catheterization, when warranted. (T. 22-26).

14. Respondent failed to document any blood pressure measurements during the nuclear stress test administered to Patient A on March 24, 2000, which deviates from the standard of care as it is clinically and diagnostically critical to monitor cardiovascular response to exercise, over time and with increasing workload, during all stress tests. (Dept. Ex. 3A, p. 173; T. 22-23, 44-45, 136-137).

15. It is important to monitor kidney function in a patient with coronary artery disease, especially when the patient also has a Triple A. Decreasing function may indicate decreased blood flow to the kidneys possibly due to the involvement of the aneurysm with the renal arteries. (T. 111, 144).

16. Respondent ordered blood work for Patient A on July 27, 1999, four months after his quintuple bypass surgery, but failed to order additional blood work until two years later, during the July 27, 2001 office visit. Patient A was on statin therapy throughout this period of time, which could adversely affect liver function. In addition, his 1999 blood work showed an abnormal fasting glucose level and elevated blood urea nitrogen (BUN), indicting some kidney dysfunction. Respondent deviated from the standard of care when he failed to adequately monitor Patient A's lipid profile as well as liver and kidney function. (Dept. Ex. 3A, pp. 59-60, 45-50; T. 143-144).

17. Patient A's kidney function was deteriorating as his creatinine levels worsened from 1.3 in July of 1999 to 1.5 in July of 2001. (Dept. Ex. 3A, pp. 59-60, 47-50).

18. On February 22, 2002, Patient A complained of exertional shortness of breath, and Respondent performed an echocardiogram and stress echocardiogram. Respondent documented in that visit's office note that the stress echo showed mild inferior wall ischemia extending from base to apex. Despite this finding, Respondent did not change or adjust Patient A's treatment plan. (Dept. Ex. 3A, p. 14; T. 153-155).

19. Less than one month later, on March 19, 2002, Respondent performed a medically unwarranted nuclear stress/profusion study on Patient A. The patient was unable to exercise to his target heart rate; therefore, the exercise test was non-diagnostic. Adding the nuclear component with submaximal exercise does not yield more information as it is again a non-diagnostic test. Under these circumstances of presumed worsening ischemia, a reasonably prudent cardiologist would need to perform a different test. Once again, Respondent did not change or adjust Patient A's diagnostic and treatment plan. (Dept. Ex. 3A, pp. 15, 22; T. 155-156).

20. Patients who undergo nuclear stress/perfusion studies are exposed to hundreds of times more ionizing radiation than would be their exposure during a simple chest x-ray. A reasonably prudent cardiologist would not perform this test regularly on a patient with suspected ischemic heart disease. Moreover, the performance of any diagnostic test on a patient in a clinical setting is only justified if the results will make a difference in treatment. (T. 260-262).

21. Respondent failed again to document any blood pressure measurements during the nuclear stress test administered to Patient A on March 19, 2002, which deviates from the standard of care as described within. (Dept. Ex. 3A, p. 22; T. 22-23, 156-157).

22. On January 16, 2003, Patient A collapsed at home in the bathroom complaining of lower abdominal pain radiating to the back after having had a bowel movement. Despite his knowledge of the patient's Triple A and climbing hypertension, Respondent instructed that the patient be given Tylenol and brought to his office at 1:00 p.m. Instead, Patient A was brought by ambulance to the hospital with advanced cardiac life support (ACLS) in progress at 11:38 a.m. (Dept. Ex. 3C, p. 32).

23. Upon arrival at the Emergency Department, Patient A was in full asystolic and cardiopulmonary arrest with an irregularly shaped and grossly distended abdomen. He was resuscitated per ACLS

protocol and stabilized in the ER, then brought for a CT scan of his brain and abdomen. Respondent was present in the CT suite during the scans. (Dept. Ex. 3C, pp. 12-14, 17).

24. Respondent should have been acutely aware of the most probable cause of Patient A's condition given the patient's history and presenting symptoms, most specifically the irregularly shaped and grossly distended abdomen. (T. 168).

25. The CT scan taken showed a ruptured juxtarenal abdominal aortic aneurysm measuring 9 centimeters in its largest anterior/posterior diameter. A large retroperitoneal hematoma is identified in the right abdomen. Before emergency surgery to repair the rupture could begin, Patient A coded once again, but this time was unable to be revived. Time of death was 2:50 p.m. (Dept. Ex. 3C, pp. 14, 17, 20).

26. Respondent's care of Patient A grossly deviated from the standard of care. Patient A died at 60 years of age from a ruptured abdominal aortic aneurysm. Respondent had actual knowledge of this aneurysm for three years. Patient A paid regular visits to his office, which meant Respondent had the obligation and opportunity to adequately follow it along with his other cardiac issues. The fact that the aneurysm was discovered before its rupture should have been fortuitous. Respondent's neglect deprived Patient A of the chance to have the aneurysm fixed and to live longer. (T. 168).

27. Respondent was not aware of the precise location of Patient A's abdominal aortic aneurysm (Dept. Ex. 3A, pp. 12, 13, 19, 58; Dept. Ex. 3C, p. 20; T. 538-547, 785).

28. Respondent altered the medical record of Patient A, by falsely documenting that he performed abdominal ultrasounds on October 13, 2000 and August 18, 2002. The patient record contains no primary data of these ultrasounds. Respondent also altered the medical record of Patient A by creating and inserting false copies of letters addressed to Victor Ribeiro, M.D. reporting that abdominal untrasounds had been performed. Patient A had only been seen by Dr. Ribeiro on two occasions, the

latter of which was in 1996, and Respondent never sent copies of the letters to him. (Dept. Ex. 3A, pp. 12, 13, 19, 58: Dept. Ex. 3B; T. 137-143).

29. Respondent altered the medical record of Patient A, by falsely documenting that he counseled the patient regarding the need for consistent follow-up to assess the abdominal aortic aneurism every three to six months. Although Patient A was in Respondent's office for a visit at the time this note was purportedly made on August 10, 2001, Respondent did not perform an ultrasound or indicate the reason one was not performed (Dept. Ex. 3A, p.13; T. 149-150).

Patient B

30. During the period between on or about March 1, 2001 through April 22, 2005, Respondent was Patient B's cardiologist. (Dept. Ex. 4, pp. 56-79).

31. Respondent took over Patient B's care from an associate physician on March 1, 2001, one year after his last visit to the practice. At that time, Patient complained of exertional chest pain. Patient B was a 62-year-old man with a previous history of hypertension, stroke, leg ulcers with venostasis (slow blood flow) and prostate cancer requiring prostatectomy followed by a penile implant. He completed his radiation and surgical therapies in 1998 and was cured of his prostate adenocarcinoma. (Dept. Ex. 4, pp. 56, 114-115, 182-183, 284-287, 292).

32. Respondent deviated from the standard of care by failing to get a complete medical history, including prior treatments and current medications, and failing to perform an adequate physical examination with a review of systems. Most notably, Patient B's initial and subsequent complaints of exertional chest pain were never fully elucidated with notations indicating its nature and severity, when it started, what brought it on, what relieved it, how often it occurred and if it has been changing over time. Such information is clinically important in formulating a differential diagnosis for the chest pain,

guiding the diagnostic approach which directs appropriate treatment modalities. (Dept. Ex. 4, p. 56; T. 216-217, 796-797, 806).

33. Respondent received payment from Patient B's insurance company for an echocardiogram of Patient B on March 1, 2001, which he did not perform. No record exists of any echocardiogram for that day in the medical record, nor is there any indication of the echo results in the office visit notes. (Dept. Ex. 4, pp. 6-7, 56).

34. On March 14, 2001, Respondent performed an exercise nuclear stress test on Patient B which was completely non-diagnostic for ischemia or electrocardiogram (EKG) changes, as the patient only exercised for 3 minutes and 58 seconds and did not achieve his target heart rate (101 beats per minute rather than 134). Respondent deviated from the standard of care by failing to obtain a meaningful diagnostic cause for Patient B's exertional chest pain through other means, as the patient might have been a candidate for revascularization or needed an adjustment to the medical management of his condition. Other available diagnostic modalities available included the use of a pharmacologic agent to increase the patient's heart rate to target, a CT scan of the coronary arteries with contrast or cardiac catheterization. (Dept. Ex. 4, p. 95; T. 22-26, 221, 231, 777-778).

35. In addition, Respondent failed to document any blood pressure measurements during the nuclear stress test administered to Patient B on March 14, 2001, which deviates from the standard of care. (Dept. Ex. 4, p. 95; T. 22-23).

36. On July 3, 2001, Respondent performed a carotid doppler study on Patient B finding atherosclerotic changes in both carotid arteries. The study was performed three months after Patient B complained of dizziness, and Respondent indicated some clinical finding related to the patient's right carotid. Despite this finding and subsequent test result, Respondent did not follow the standard of care and prescribe aspirin therapy or a statin drug for Patient B, nor did he indicate any contraindications for

such treatment for this patient. The only notations Respondent included on Patient B's office note for July 3, 2001 were his height and weight. (Dept. Ex. 4, pp. 38, 58).

37. On February 13, 2004, March 22, 2004 and April 13, 2004, Respondent documented Patient B's blood pressure at 160/90, 160/94 and 160/84 respectively, yet failed to prescribe any anti-hypertensives. This was a deviation from the standard of care; especially as such medication would be the standard treatment for Respondent's earlier purported diagnosis of Patient B's diastolic dysfunction as well. (Dept. Ex. 4, pp. 12-13, T. 236-238).

38. Respondent performed four non-diagnostic nuclear stress tests on Patient B on March 14, 2001, May 1, 2002, July 30, 2003 and August 4, 2004. He documented these tests as normal, even though they were non-diagnostic. Respondent deviated from the standard of care by unnecessarily exposing Patient B to ionizing radiation (through radioactive contrast material) as well as by failing to order alternative, definitive diagnostic tests to seek diagnoses for the symptoms he documented as prompting the stress tests, including exertional chest pain, palpitations and shortness of breath. (Dept. Ex. 4, pp. 40, 45, 48, 95; T. 56, 63-64, 68, 75, 252-255).

39. Respondent does not identify the dose or rate of administration of the nuclear isotope he used during the July 30, 2003 nuclear stress test he administered to Patient B, which deviates from the standard of care. Respondent also falsely represents that Patient B achieved his target heart rate of 133 beats per minute when in fact the data sheet reveals that it never got above 106 beats per minute. (Dept. Ex. 4, pp. 44-45).

40. In a span of only four years, from March of 2001 through March of 2005, Respondent performed eleven stress tests (four of which included the use of a nuclear isotope) on Patient B. The eleven tests were non-diagnostic yet documented as normal, deviating from the standard of care. In addition, Respondent performed four abdominal ultrasounds (for pain and a reported pulsatile abdominal aorta yet

these findings are non-existent in the initial office note), five carotid doppler studies (for purported yet non-specified dizziness) and four echocardiograms (each purportedly revealing diastolic dysfunction, but consistently failing to stage it). This amounts to twenty-four largely negative cardiac tests. (Dept. Ex. 4, pp. 3, 20-23, 27-29, 32-40, 42-45, 47-48, 50-51, 58, 80-81, 95, 179, 335; T. 25, 231, 241-243, 246-247, 255, 259, 266-267, 809-811).

41. Respondent only occasionally documented the medications Patient B was taking. There is very little to no indication as to how any of the numerous diagnostic tests performed on Patient B directed or influenced his treatment. It is a deviation from the standard of care to regularly perform non-diagnostic tests as well as repeat tests with no discernible medical rationale or change in treatment. (Dept. Ex. 4, pp. 56-79; T. 262-263, 802-804).

Patient C

42. During the period between on or about May 29, 2002 through on or about February 1, 2006 Respondent was Patient C's primary care physician as well as her cardiologist. (Dept. Ex. 5, pp. 4, 10, 78, 84, 213, 268).

43. On May 29, 2002, Respondent sent Patient C to the Emergency Department at St. John's Riverside Hospital (SJRH) with suspected congestive heart failure (CHF). At that time, Patient C was a 59-year-old woman with a history of cardiomyopathy, a leaky heart valve, hypertension, asthma and diabetes mellitus. (Dept. Ex. 5, pp. 213-214, 268).

44. Patient C was admitted to the hospital with a diagnosis of dilated cardiomyopathy (disease of the heart muscle), CHF, hypertension and diabetes, and Herbert Schoen, M.D. referred Patient C to Respondent for a cardiac consultation. The hospital's admission registration form identifies Respondent as Patient C's primary care physician as well as the May 29, 2002 admitting and attending physician, notwithstanding the referral. Dr. Schoen definitively documented the transfer of the patient's care in the

hospital to Respondent on May 31, 2002, after which Respondent wrote the orders for Patient C who remained at that hospital until her transfer to Westchester County Medical Center (WCMC) on June 2, 2002. (Dept. Ex. 5, pp. 213-214, 224, 228, 258, 292).

45. During the stay at SJRH, Patient C experienced significant cardiac arrhythmias including ventricular bigeminy, frequent premature ventricular contractions (PVCs) and an episode of ventricular tachycardia. Ventricular tachycardia is a fast heart rhythm arising in the lower chambers of the heart, which can be fatal if sustained. Respondent documented this episode on May 31, 2002, at which time he was in charge of Patient C's care. (Dept. Ex. 5, pp. 227, 246, 249; T. 271-272, 740-741).

46. A cardiac patient admitted to a hospital should be visited by her attending or covering physician at least daily during the stay, especially when such patient has potentially dangerous arrhythmias. (T. 272-274, 823-824).

47. Patient C was transferred to WCMC on June 2, 2002 for an electrophysiology study and a possible implantable defibrillator (AICD). The last note indicating that Respondent saw Patient C was written by him on May 31, 2002, and no other physician note appears in Patient C's hospital record thereafter. (Dept. Ex. 5, pp. 217-218, 227, 258).

48. Respondent did not provide a transfer note for Patient C. This deviates from the standard of care because it is critical when transferring a patient from one facility to another that the receiving facility understands the reason for the transfer including the transferring physician's thinking about the various test results and physical examinations, medications and treatments along with the history of the patient in some detail. (T. 272-273, 286).

49. On March 30, 2005, Respondent again sent Patient C to the Emergency Department at SJRH when she complained of chest pain, shortness of breath and a fast heartbeat, her cardiac pacemaker having been implanted in 2002. (Dept. Ex. 5, p. 77-84).

50. Diagnostic tests were performed on Patient C at SJRH during the course of her stay there, including blood work and electrocardiograms (EKGs), until her transfer to Mount Sinai Hospital for cardiac catheterization on April 3, 2005. (Dept. Ex. 5, pp. 98-110).

51. Respondent was Patient C's primary care, admitting and attending physician/cardiologist for this hospital stay. Only two short notes appear in Patient C's hospital record dated April 1 and April 2, 2005, and each fails to clinically assess the reason for her rapid heartbeat, severely high hemoglobin A1C, low potassium and high blood glucose levels or to analyze her EKGs and cardiac function and/or to provide a comprehensive assessment and plan. (Dept. Ex. 5, p. 95).

52. In Patient C's previous SJRH hospital admission of May of 2002, she was identified as having an allergy to aspirin. (Dept. Ex. 5, pp. 255, 258; T. 752-753).

53. In March of 2005, Respondent includes daily Ecotrin (coated aspirin) in his physician orders and transfer form for Patient C with no documented explanation as to why she could safely take aspirin at this time. (Dept. Ex. 5, pp. 85, 111; T. 753-755, 824).

54. Respondent transferred Patient C to Mount Sinai Hospital for cardiac catheterization on April 3, 2005, once again failing to provide an adequate transfer note to the receiving facility with any complete or meaningful information. Moreover, there was no indication in the medical record that Respondent attempted any other form of communication with the receiving facility. (Dept. Ex. 5, pp. 85-86, 142, 818-819).

55. The transferring physician is responsible for ensuring that all of a patient's current medications are documented on the transfer form so that the institution assuming that patient's care can properly administer those medications. Respondent had recently prescribed Amiodarone in increasing doses for Patient C to help control her arrhythmia, but he failed to include it on her transfer form to Mount Sinai.

This was a medically significant and potentially dangerous omission. (Dept. Ex. 5, pp. 85-86, T. 755-756, 825).

56. On January 29, 2006, Patient C was taken by ambulance to the Emergency Department at SJRH after she fainted. Respondent was Patient C's primary care, admitting and attending physician/cardiologist for this hospital stay. (Dept. Ex. 5, pp. 4, 8, 10, 53).

57. Only two short notes appear in Patient C's hospital record dated January 30 and January 31, 2006, and each fails to clinically assess her blood chemistry, analyze her EKGs and/or provide a comprehensive assessment and plan. (Dept. Ex. 5, pp. 13, 17, 21-41).

58. Notwithstanding the computer print-out of Patient C's AICD device, there is no report by Respondent analyzing the data and describing the events or cause of the syncopal episode, which deviates from the standard of care. (Dept. Ex. 5, p. 16; T. 275-276).

59. When Respondent discharged Patient C on February 1, 2006, he failed to provide an adequate follow-up plan in the discharge summary and her medication list was incomplete. (Dept. Ex. 5, pp. 6-7).

Patient D

60. During the period between on or about May 5, 2003 through August 6, 2005, Respondent was Patient D's cardiologist. (Dept. Ex. 6, pp. 16-27).

61. On May 5, 2003, Patient D, a 62-year-old man, visited Respondent's office complaining of chest pain and shortness of breath on exertion, palpitations, dizziness, an episode of blurred vision and numbness on the left side a few days ago, and syncope the day before. He had a past medical history of hypertension and prostate cancer, and a family history of hypertension and diabetes. Patient D also smoked a pack of cigarettes daily. Respondent fails to specify the duration of the smoking history. (Dept. Ex. 6, pp. 16-17, 51-52; T. 623-624).

62. Respondent failed to properly assess Patient D's chief complaints including the circumstances surrounding Patient D's fainting episode, blurred vision and left-sided numbness, any indication of whether the chest pain was stable/unstable or increasing, and whether or not the palpitations were associated with the dizziness. Respondent failed to seek emergent care for Patient D for possible stroke and acute coronary syndrome at this visit, which deviates from the standard of care. (T. 301-304).

63. Respondent performed an EKG on Patient D which was abnormal, furthering the evidence that Patient D had significant coronary artery disease. (Dept. Ex. 6, pp. 23-24, T. 302-303).

64. Respondent failed to appropriately evaluate and treat Patient D on May 5, 2003, given his abnormal EKG and presenting symptoms suggestive of a range of both cardiac and neurologic conditions that put him at immediate risk for life threatening complications such as sudden cardiac death. Notwithstanding this risk, Respondent scheduled Patient D for stress testing in his office just a few days later, thereby exposing him to even greater risk by exercising an ischemia compromised heart. This was a severe deviation from the standard of care. (T. 301-310, 316, 840).

65. On or around May 9, 2003, Respondent performed a suboptimal nuclear stress test on Patient D rendering it non-diagnostic. Nonetheless, the test did reveal mild apical inferior ischemia even with submaximal exercise suggesting that the ischemia may have actually been worse. Respondent failed to seek a different test for Patient D that would yield a diagnostic result such as a cardiac catheterization. Respondent also failed to prescribe a beta blocker, statin or aspirin for Patient D at this time even with the diagnosed ischemia finding and Patient D's less than optimal lipid profile. Procardia was the only medication Patient D was taking. The unwarranted administering of a nuclear stress test and the failure to adequately diagnose and treat Patient D are both severe deviations from the standard of care. (Dept. Ex. 6, pp. 26, 30, 39-42; T. 306-309, 842).

66. In addition, Respondent failed to document any blood pressure measurements during the nuclear stress test administered to Patient D on or about May 9, 2003, which deviates from the standard of care. (Dept. Ex. 6, p. 30).

67. Respondent reported three significantly different numbers for Patient D's ejection fractions for the May 9, 2003 nuclear stress (75%) and echocardiogram (55% and 45%), which is not physiologically possible. The ejection fraction is one of the most important numbers a cardiologist has to ascertain the functional condition of the heart and actually predict mortality as well as direct treatment. Therefore, it needs to be measured accurately to comport with the standard of care. (Dept. Ex. 6, pp. 29, 38, 43; T. 27-28, 306-307).

68. Three months later, Patient D came to Respondent's office on August 6, 2003, complaining of left-sided chest pain and shortness of breath, which Respondent again failed to detail. The EKG that was taken showed new ST segment elevations in the anterior leads that suggest either aneurysm formation or new ischemia. Notwithstanding this new finding, Respondent had Patient D undergo another non-diagnostic exercise stress test and stress echo that very day, recklessly exposing Patient D once again to unnecessary risk. (Dept. Ex. 6, pp. 22, 35; T. 309-310, 843-844).

69. Respondent also failed to document any blood pressure measurements during the stress test administered to Patient D on August 6, 2003, deviating from the standard of care. (Dept. Ex.6, p. 35).

70. Respondent falsely billed for a January 17, 2005 nuclear stress test and a February 23, 2005 Holter monitor test which he did not perform. No documentation or report of these tests is contained in the medical record for Patient D. (Dept. Ex. 6, pp. 8-9, 16; T. 311-312).

71. Respondent's medical record for Patient D contains two handwritten office visit reports for that same visit which differ in content (i.e., allergies addressed in one report and not the other; "unremarkable" family history noted in one report with hypertension and diabetes listed in the other,

etc.). This constitutes substandard recordkeeping and substandard care. (Dept. Ex. 6, pp. 16-17, 51-52; T. 300-301).

Patient E

72. During the period between on or about July 21, 2000 through October 10, 2005, Respondent was Patient E's cardiologist. (Dept. Ex. 7, pp. 29-45, 127-128).

73. On July 21, 2000, Patient E, a 61-year-old woman, visited Respondent complaining of "atypical" chest pain, shortness of breath and palpitations. She had a history of hypertension, diabetes and hyperlipidemia. At 5'1", she weighed 154 pounds. (Dept. Ex. 7, pp. 28-29, 34; T. 317-381).

74. The history, physical and clinical examination for this first visit was inadequate. The characteristics of her chest pain, such as its origin, frequency, duration, nature, relation to exertion and precipitating/relieving factors were not addressed. It was simply labeled "atypical." There was no order for any laboratory evaluation, and no medications were listed except for Cozaar which Respondent replaced with Atenolol presumably due to her cough. The clinical exam and EKG were documented as normal. Respondent did not include any plan to evaluate the cause of the chest pain, deviating from the standard of care. (Dept. Ex. 7, pp. 28-29; T. 317-318).

75. Respondent received payment from Patient E's insurance carrier for purportedly performing a nuclear stress test, echocardiogram and carotid ultrasound on Patient E on August 8, 2000. Only a stress test data sheet is in Patient E's medical record, and there is no indication of the other two tests in the visit notes. Also, no signed consent appears in this patient's record, which is required to comport with the standard of care. Respondent falsely billed for the echocardiogram and carotid ultrasound, having not performed them. Respondent also fabricated a reduced right carotid pulse finding (after documenting it as normal just two weeks before) on the clinical exam office note, to justify the unnecessary ultrasound. (Dept. Ex. 7, pp. 2-3, 20, 106; T. 318-319).

76. Respondent diagnosed Patient E with coronary artery disease (CAD) on August 8, 2000, although the record at this time contains little to support that diagnosis. The stress test administered that day indicated that the patient reached her target heart rate (rendering it a diagnostic test), exercising for 8 minutes and 15 minutes, with no indication that the test was abnormal. Again, no blood pressure measurements appeared on the data sheet. No lab tests were ordered, no statin or aspirin was prescribed, and no indication for failing to prescribe those standard medications in a patient diagnosed with CAD was documented. This standard of care falls below minimally accepted standards in cardiology. (Dept. Ex. 7, p. 20; T. 318-319, 859).

77. Respondent falsely billed for having performed another carotid doppler and echocardiogram of Patient E on September 10, 2001, which he did not perform. No record of these tests are in the patient's medical record. (Dept. Ex 7).

78. On October 1, 2001, Respondent performed another nuclear stress test on Patient E, which was non-diagnostic this time. Respondent performed no further testing at that time to determine whether or not Patient E actually had ischemia, despite Patient E's current and continuing chest pain and shortness of breath complaints. (Dept. Ex. 7, p. 32, 99, T. 320).

79. Over one month later, on November 2, 2001, Respondent purportedly performed a diagnostic stress echocardiogram on Patient E which was reported negative for ischemia. No record or mention of this test is contained in the patient's medical record, yet Patient E's insurance carrier paid Respondent for the test. Respondent falsely billed for this test with the knowledge that he did not perform it. (Dept. Ex. 7, pp. 6-7, 32).

80. Respondent falsely billed for the following tests that are absent in, or measurements are altered from, the original certified record with the knowledge that he did not perform them, and he fabricated the medical records to support his false billing: a September 23, 2002 echocardiogram, a September 23,

2002 carotid doppler study, an August 12, 2003 abdominal aorta study, a March 8, 2004 echocardiogram, a March 8, 2004 abdominal aorta study, a March 29, 2004 carotid doppler study, an April 1, 2005 carotid doppler study, and a July 15, 2005 abdominal aortic ultrasound. (Dept. Ex. 7, pp. 8-17, 66, Resp. Ex. L pp, 24-27, 51, 54-56, 78-79, 100-101, 129; T. 321-330).

81. Within the span of only two and one half years, Respondent performed four nuclear stress tests on Patient E, exposing her unnecessarily to repeated radiation (August 8, 2000, October 1, 2001, December 13, 2002 and March 29, 2004). These tests were diagnostic and normal. (Dept. Ex. 7, pp. 49, 99, 102, 106, 201; T. 866-868).

82. Respondent falsely billed for having performed another carotid doppler and echocardiogram of Patient E on September 10, 2001, which he did not perform. No record of these tests is contained in the patient's medical record (Dept. Ex. 7).

83. In addition, Respondent performed four unwarranted exercise stress tests on Patient E in a little more than 2 years (May 1, 2003, June 23, 2004, April 1, 2005 and July 15, 2005). All but one of these test were diagnostic, and all were normal. (Dept. Ex. 7, pp. 18, 24, 55-56, 65, 67, 224).

84. Patient E consistently complained of chest pain as well as shortness of breath, palpitations and dizziness during the many visits she paid to Respondent's office, who repeated over and over again cardiac stress tests that yielded no new information regarding her chest pain complaints. (Dept. Ex. 7; T. 318-330).

85. Respondent performed a MUGA scan on Patient E on August 19, 2005, which is another kind of nuclear test designed to measure ventricular size and evaluate left ventricular heart function. There was no medical reason for this MUGA scan, especially in light of prior essentially normal echocardiograms. (Dept. Ex. 7; T. 329-330).

86. Respondent failed to provide a definitive assessment of Patient E's anatomy by other diagnostic means to determine whether or not her chest pain was indicative of significant obstructive coronary artery disease or something else. Respondent deviated from the standard of care when he continued to expose Patient E to the risk of multiple stress tests, often coupled with radiation exposure, with no possible medical expectation that these tests would yield her any benefit. (Dept. Ex. 7, pp. 694-697, 877-880).

Patient F

87. During the period between January 14, 2005 and October 19, 2005, Respondent was Patient F's cardiologist. (Dept. Ex. 8, pp. 12-15, 20-24, 113-114).

88. On January 14, 2005, Patient F, a 58-year-old man, visited Respondent's office complaining of chest pain and shortness of breath on exertion, palpitations, dizziness with left-sided weakness and an episode of slurred speech. He had a history of hypercholesterolemia and mild hypertension and a strong family history of coronary artery disease. (Dept. Ex. 8, pp. 20-21; T. 331-332).

89. Respondent failed to properly assess Patient F's chief complaints including a failure to document the circumstances surrounding Patient F's episode dizziness, left-sided weakness and slurred speech, any characterization of the chest pain as stable/unstable or increasing, and any indication as to whether the palpitations were associated with the dizziness. There was no order for any laboratory evaluation, and no medications were listed. Respondent's note in the medical record states that an EKG was normal, but no report of the EKG is in the patient's record, as is required. (Dept. Ex. 8, pp. 20-21; T. 331-332, 893).

90. Respondent performed several diagnostic tests on Patient F on January 19, 2005, including a stress test, echocardiogram and carotid doppler study, documenting essentially normal results. (Dept. Ex. 8, pp. 3-4, 6-7, 12-13).

91. Respondent received payment from Patient F's insurance carrier, Empire Blue Cross/Blue Shield (BCBS), in the amount of $2500 for purportedly performing a nuclear stress test on Patient F on January 19, 2005. It was itemized as follows: nuclear stress test $1600, stress test interpretation $500, myocardial perfusion (nuclear scan) $200 and 2 dose myoview (nuclear isotope) $200. (Dept. Ex. 8, pp. 12-13).

92. Respondent reimbursed BCBS $743.23 on August 25, 2005. Patient F did not receive a nuclear stress test on January 19, 2005, but Respondent alleged the patient received a simple exercise stress test. His reimbursement was itemized as follows: $463.77 (from the $1600) for the nuclear stress test, $79.46 (from the $200) for the nuclear scan and $200 for the nuclear isotope. (Dept. Ex. 8, pp. 10-14; T. 713-714, 732).

93. After refunding the $200 for the nuclear isotope that he admittedly did not use on Patient F during the January 19, 2005 stress test, Respondent received $200 for the nuclear isotope from Patient F's second insurance carrier on November 8, 2005. Respondent billed this charge falsely. There is no indication in the record that this $200 was reimbursed to the second carrier. (Dept. Ex. 8, p 114; T. 332-334).

94. Respondent deviated from the standard of care and exposed Patient F to a stroke risk when he performed the January 19, 2005 exercise stress test on this patient with significant neurological symptoms, without first discovering the cause of the symptoms. The results of Patient F's cardiac tests were normal, yet Respondent failed to make an appropriate referral to a neurologist, and there is no indication in the record that Respondent communicated with Patient F's primary care physician about the need for this referral. (T. 336-337; 894-895, 895-897).

95. Respondent billed for two physical examinations for Patient F on January 19 and 21, 2005, respectively, for which no office notes appear in the patient's medical record. Respondent falsely billed for these two examinations with the knowledge that he did not perform them. (Dept. Ex. 8, pp. 12-13).

96. Respondent also purportedly performed a stress echocardiogram on Patient F on January 19, 2005 for which no records exist in the patient's medical record, yet Patient F's insurance carrier paid Respondent for the test. Respondent falsely billed for this test with the knowledge that he did not perform it. (Dept. Ex. 8, p. 12, T. 334-335).

97. Patient F returned to Respondent's office on April 21, 2005 complaining of chest pain, shortness of breath and palpitations. There is no indication that an EKG was performed, deviating from the standard of care. Respondent documented a normal clinical exam and, he performed another stress test without a prior EKG. (Dept. Ex. 8, pp. 16, 22, 54; T. 337-338).

98. On April 22, 2005, the day after Respondent performed a stress test on Patient F, he performed an EKG on him which was borderline abnormal. (Dept. Ex. 8, p. 167).

99. On July 20, 2005, Patient F visited Respondent's office complaining of shortness of breath, palpitations, dizziness and leg claudication (cramping). Respondent purportedly performed an arterial doppler of Patient F's lower extremities and an abdominal aorta study, for which no data or reports exist in the patient's medical record. Respondent falsely billed for these tests with the knowledge that he did not perform them. (Dept. Ex. 8, p. 23).

100. On October 13, 2005, Patient F repeated his prior visit's complaints. Respondent purportedly performed a MUGA scan on Patient F, but there was no medical indication for the test, especially in light of the normal echocardiogram six months prior and an unchanged clinical presentation. Respondent falsely billed for this test with the knowledge that he did not perform it. (Dept. Ex. 8, p. 24; T. 337-338).

101. Respondent never formulated a plan to manage Patient F's clinical signs and symptoms beyond the performance of the diagnostic tests in his record. (Dept. Ex. 8; T. 338).

Patient G

102. During the period between on or about March 7, 2001 through September 22, 2005, Respondent was Patient G's cardiologist. (Dept. Ex. 9, pp. 83-100).

103. Respondent took over Patient G's care from an associate physician on March 7, 2001. At that time, Patient G was a 60-year-old, 5'8", 246-pound man complaining of exertional shortness of breath and chest pain. No medical history or current medications were documented nor was there any elucidation as to the cause of this patient's complaints at that visit. An EKG was performed, and Respondent indicated "no change." The physical examination indicated that Patient G's lungs were clear, his pulse in the right carotid was decreased and included a diagram next to abdomen/extremities and some initials next to heart, both of which cannot be deciphered. This H&P fails to meet the standard of care. (Dept. Ex. 9, p. 60, 83; T. 41-42).

104. Respondent documented diagnoses of coronary artery disease (CAD), angina, hypertension and diabetes. At the hearing, Respondent testified that Patient G also had bronchial asthma for which he was on bronchodilators and that his blood pressure was controlled with ACE inhibitors, but this information was not included in Respondent's chart for Patient F's initial visit to him on March 7, 2001. (Dept. Ex. 9, p. 83; T. 462-463).

105. Despite Respondent's notation on March 7, 2001 of his intention to obtain a stress test for Patient G, one is not obtained until almost a year later, notwithstanding that Patient G visited his office three times after his initial visit with similar complaints. (T. 83-84).

106. Respondent obtained payment from Patient G's insurance carrier for a June 29, 2001 carotid doppler study, a July 2, 2001 abdominal aorta study, and a September 18, 2001 arterial doppler

study. Respondent falsely billed for these tests with the knowledge that he did not perform them. (Dept. Ex. 9, pp. 11-12).

107. Respondent billed Patient G's insurance company for a follow-up visit on June 29, 2001 for which no record exists in his office notes. Respondent falsely billed for this visit with the knowledge that he did not examine Patient G on that day. (Dept. Ex. 9, pp. 11, 83-84).

108. Respondent performed a nuclear stress test on Patient G on October 11, 2002, in which the patient reached his target heart rate, yet the blood pressure measurements were not documented. This deviates from the standard of care. Respondent documented that the test was negative for ischemia. (Dept. Ex. 9, pp. 33, 44-45, 185).

109. In a span of less than three and a half years from February of 2002 through June of 2005, Respondent performed seven stress tests (two of which included the use of a nuclear isotope) on Patient G. Six of the seven tests were diagnostic and reported as normal, notwithstanding the absence of blood pressure measurements in most of them. (Dept. Ex. 9, pp. 31-33, 36-37, 39, 52, 106, 167, 169, 181, 183, 185).

110. Patient G visited Respondent's office on December 18, 2003 complaining of chest pain and shortness of breath. Respondent noted that he would perform a nuclear stress test, which he did on December 23, 2003 along with a carotid doppler study. One of the indications for the doppler study was amaurosis fugax (loss of vision). There is no indication in the record that Respondent examined Patient G before stressing him that day, nor is there any documentation describing the circumstances of his vision loss or any neurologic examination. (Dept. Ex. 9, pp. 35, 64).

111. During the December 23, 2003 nuclear stress test, Patient G's heart rate dropped as he continued to exercise which is an ominous sign suggesting dangerous cardiac or neurological problems. Despite this finding, Respondent failed to immediately terminate the test and seek emergency diagnostic

care and treatment for Patient G. Patient G sought Emergency Room care on his own the following day and was admitted to SJRH with a stroke. The care and treatment provided to Patient G by Respondent severely deviated from the standard of care. Respondent's failures were many and compounded each other. He stressed Patient G without any medical indication as he had a normal stress echocardiogram just seven months prior; he failed to refer Patient G to a neurologist or ophthalmologist for the vision loss; he decided to go ahead and stress Patient G putting him at risk for a major neuro-cardiac event; he failed to examine him before the stress test, and he virtually abandoned Patient G after the stress test. These actions all but certainly precipitated Patient G's neurological event. (Dept. Ex. 9, pp. 36, 53, 67-72, 169, 269-270; T. 336, 487-490, 496-500, 505-506).

112. The nuclear stress test that Respondent performed on Patient G on December 23, 2003 exposed Patient G to increased risk, resulting in his hospitalization with a cerebrovascular accident. (Dept. Ex. 9, pp. 36, 53, 67-72, 169, 269-270; T. 487-490, 496-500).

113. The other numerous diagnostic tests performed on Patient G both before and after the events of December 23, 2003, including multiple echocardiograms, carotid doppler studies and peripheral artery ultrasounds never actually diagnosed anything, nor did they direct any efficacious treatment, as Patient G's symptoms persisted throughout the years he was Respondent's patient. (Dept. Ex. 9, pp. 83-100, 35, 38, 40, 42, 43, 46, 183).

Falsification of Patient Records

114. During the course of the investigation conducted by the Office of Professional Medical Conduct ("OPMC"), Respondent provided copies of the medical records of his patients. Respondent certified that the records of Patients B, D, E, F and G were "complete, true and exact copies/originals of the patient records kept on file during the regular course of business and were made at the time of such event as recorded or written." (Dept. Ex. 3A, 4, 6, 7, 8 and 9).

115. The Department served Respondent with a Notice of Hearing and Statement of Charges in this proceeding dated November 10, 2011. The Statement of Charges outlined the allegations of misconduct regarding these seven patients (Dept. Ex. 1).

116. At the hearing on December 15, 2011, Respondent submitted a new set of documents which he claimed to be additional portions of the medical records for Patients A, B, D, E, F and G which he had not previously provided. (Resp. Ex. H, I, K, L, M and N).

117. At the hearing on January 24, 2012, Respondent submitted still additional documents for Patients B, E and F (Resp. Ex. Q, Ex. E, p. 44A; and Ex F, p. 24A and 24B).

118. At the hearing on February 9, 2012, Respondent submitted still additional documents for Patient A and G (Resp. Ex. R and S).

119. The additional documents submitted by Respondent allegedly as part of Patient A's record includes reports of echocardiogram and carotid doppler studies purportedly performed on July 21, 2001, yet there is no documentation that Patient A paid an office visit to Respondent on July 21, 2001. Further, neither study is mentioned in the note of a subsequent July 27, 2001 office visit. Additionally, there are two reports presumably for the same July 2001 doppler study which are different in form and content, and one is dated July 21 and the other July 27. (Resp. Ex. H, pp. 10-11, 32-33; T. 144-147).

120. The July 21, 2001 echocardiogram report in the new set of documents diagnoses Patient A with diastolic dysfunction and trace mitral and tricuspid regurgitation. Diastolic dysfunction indicates that the ventricular heart wall has become stiffer, interfering with its function which can produce symptoms of shortness of breath. This same diagnosis is found in the records submitted for Patients B, D, E, F and G. (Resp. Ex. H, p. 10, T. 237-238, 430-432).

121. A report for a March 19, 2002 stress test contained in the set of documents for Patient A submitted at the hearing in December 2011 includes blood pressure measurements that were not in the

original record submitted to OPMC. Still later in the hearing, Respondent submitted a worksheet which was not part of the medical record initially received. (Resp. Ex. H, R).

122. The additional sets of documents submitted by Respondent for Patient A add specific data, such as indications for diagnostic tests as well as blood pressures and aortic measurements not recorded in the original reports, and new reports of tests for which Respondent received payment. (Resp. Ex. H, R; T. 448-449).

123. On July 22, 2002, Respondent purportedly performed carotid doppler and echocardiogram studies on Patient A one year after the prior year's purported studies. Respondent's carotid doppler duplicate report in the additional documents submitted at the hearing indicates that Patient A had a clinical history of "transient weakness in left upper extremity," which does not appear in the original report nor anywhere else in Patient A's medical record. (Dept. Ex. 3A, pp. 16, 20-21; Resp. Ex. H, pp. 9, 28-29.

124. Respondent submitted additional records for the March 1, 2001 echocardiogram diagnosing Patient B with diastolic dysfunction. Still later in the hearing, Respondent also submitted a handwritten expanded history and physical for the office visit on that date. Respondent did not in fact perform an echocardiogram on Patient B on March 1, 2001 and both the expanded visit notes and echo report were knowingly and falsely created. (Resp. Ex. I, pp. 12-13, Resp. Ex. Q, p. 7-8).

125. Respondent's stated during his direct testimony in this hearing that the March 1, 2001 echocardiogram report was not in the originally submitted certified record to the Office of Professional Medical Conduct (OPMC) because he discarded the original report after he "restated" the report in a format intended to conform with ICANL standards. During cross examination, however, Respondent testified that he did not originally include the echocardiogram report because he only sent what he though was essential since he did not know the exact "nature of the investigation." Respondent's

allegedly "restated report" does not indicate that it is a revision or indicate the true date on which it was prepared (T. 574, 583-585; Resp. Ex. I).

126. The blood pressure measurements documented in Respondent's later submitted report for the March 14, 2001 test are not contained in the medical record that was initially submitted to OPMC. (Dept. Ex. 4, Resp. Ex I).

127. On July 3, 2001, Respondent performed an abdominal ultrasound study on Patient B and found no significant dilatation of the aorta. The additional report for this test submitted by the Respondent at the hearing contains a clinical history created to support the need for the test, as well as detailed aortic measurements which was not contained in the patient's initially submitted medical record. (Dept. Ex. 4, p. 38, Resp. I, p. 115; T. 222-223).

128. Respondent failed to consistently identify which nuclear isotope he was employing during the July 30, 2003 nuclear stress test he administered to Patient B. The original medical record report documents sestamibi, without dose and rate of administration, while the later submitted documents indicate doses of myoview. Both reports also falsely represent that Patient B achieved his target heart rate of 133 beats per minute when the data sheet reveals it never got above 106 beats per minute. This is additional evidence of the unreliability of Respondent's records in general and the deliberate falsification of his later submitted documents in particular. (Dept. Ex. 4, pp. 44-45, Resp. Ex. I, pp. 34-35; 231-234).

129. Respondent testified at the hearing that his treatment of Patient B was thwarted by the patient's "early Alzheimer's," lack of family and refusal of cardiac catheterization. As late as November 12, 2004 (just 4 months before his last visit to Respondent), however, a board certified neurologist documented that Patient B was a married man, employed as a packer in a factory with no significant cognitive problem. (Dept. Ex. 4, pp. 182-183; T. 569, 605-612).

130. The blood pressure measurements documented in Respondent's later submitted report for the stress test of Patient D as well as the measurements in the May 9, 2005 echocardiogram report are not in the original medical record and were falsely created by Respondent. (Dept. Ex. 6, Resp. Ex. K, pp. 49-50, 64-65).

131. Respondent falsely billed for a stress echo on Patient E and fabricated a medical record to support his false billing. (Dept. Ex. 7, pp. 6-7, 32, Resp. Ex. L, pp. 22-23; T. 320-321).

132. Respondent also purportedly performed a stress echocardiogram on Patient F on January 19, 2005 for which no records exist in the original certified record, yet Patient F's insurance carrier paid Respondent for the test. Respondent falsely billed for this test with the knowledge that he did not perform it and fabricated a medical record, which he supplied mid-hearing to support his false billing. (Dept Ex. 8, p. 12, Resp M, p. 23a; T. 334-335).

133. On July 20, 2005, Patient F visited Respondent's office complaining of shortness of breath, palpitations, dizziness and leg claudication (cramping). Respondent purportedly performed an arterial doppler of Patient F's lower extremities and an abdominal aorta study, for which no data or reports exist in the patient's medical record. Respondent falsely billed for these tests with the knowledge that he did not perform them and fabricated medical records to support his false billing. (Dept. Ex. 8, p. 23, Resp. Ex. M, pp. 5-6).

134. Respondent fabricated a document to support his false billing for an October 13, 2005 MUGA scan on Patient F. (Dept. Ex. 8, p. 24; T. 337-338; Resp. Ex. M, p. 4).

135. Respondent fabricated a medical record to support his false billing of Patient G's insurance carrier for a June 29, 2001 carotid doppler study, a July 2, 2001 abdominal aorta study, and a September 18, 2001 arterial doppler study. (Dept. Ex. 9, pp. 11-12, Resp. Ex. N, pp. 90-92; T. 87-89).

136. Respondent fabricated blood pressure measurements for Patient G's stress test. (Resp. Ex. M, pp. 81-82).

137. Respondent created the additional documents admitted as Resp. Ex. H, I, K, L, M, N, Q, R and S to conceal his deficient medical care and his false billing (paragraphs 114-136 supra).

CONCLUSIONS OF LAW

Respondent is charged with forty-one specifications alleging professional misconduct within the meaning of Education Law §6530. The charges relate to gross negligence, negligence, incompetence, unwarranted testing, fraud, submitting false reports, and failing to maintain adequate patient records. The Hearing Committee made the following conclusions of law pursuant to the factual findings listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

Respondent provided copies of the medical records for the seven patients to OPMC during the course of the investigation and prior to issuance of the Statement of Charges. After the hearing commenced, Respondent initially claimed that he had produced only that portion of the patient records which he considered pertinent to the Department's investigation which he understood to be related to billing infractions. Five of the medical records which Respondent initially provided to the Department, however, are certified by Respondent as being complete. Moreover, the records submitted give no appearance of having being a deliberate subset of the patients' medical records intended to address only billing infractions. Accordingly, the Hearing Committee did not find Respondent's explanation credible.

A review of the individual patient records further disproves Respondent's claim that the initially submitted records were incomplete because he understood that he was only required to submit that portion of the patients' medical records that addressed his billing practice. For example, Respondent

billed for having performed a carotid doppler and echocardiogram of Patient E on September 10, 2001, but no record of these tests are contained in the medical record Respondent initially submitted for Patient E. At the hearing, however, Respondent's new submissions contained a detailed typed report in which he diagnoses small atherosclerotic plaque and diastolic dysfunction, findings conveniently consistent with the patient's complaints of dizziness and exertional shortness of breath. (Resp. Ex. L, pp. 5-8; T. 860-863).

Further instances of Respondent having altered the newly submitted documents to justify a medically unnecessary test can be seen. For example, there are two different reports of a July 22, 2002 carotid doppler and echocardiogram studies conducted on Patient A exactly one year to the month after the prior year's purported studies. Respondent's carotid doppler newly submitted report documents a clinical history of "transient weakness in left upper extremity" which does not appear in the report contained in the originally produced medical record for Patient A or elsewhere in the medical record.

Additional evidence of Respondent's alteration of his medical records can be seen reviewing the July 20, 2005 office visit notes for Patient F and comparing that record with his later submitted abdominal aorta study report from that same day. The report indicates "increasing abdominal pain" and a "palpable pulsatile abdominal aorta" as indications for the study to rule out a Triple A. The visit notes, however, document a normal abdominal exam and abdominal pain is never mentioned. (Dept. Ex. 8, p. 23, Resp. Ex. M, p 5).

The Department's expert witness testified that the distinct form and content of the newly submitted documents provided evidence which suggested that Respondent had created them to falsely justify the treatment he provided his patients. The content of the duplicate reports for identical tests and dates of service consistently supply more detailed medical information than is contained in the originals. Moreover, the original record contains consistent and exclusive use of one distinct written format while

the later submitted records consistently and exclusively use another and markedly different format. The later submissions use a letterhead different in size, type and content, a different physician stamp and contain no dictation identifiers. This was further evidence that Respondent's explanation of having selected only certain records related to billing infractions was false. (T. 46-50).

Confronted with the fact that the newly submitted documents showed the use of different letterhead, physician stamp, and dictation stamp than seen in the medical records for these patients during the same time period, Respondent testified that he revised his records so he could improve the documentation of his patient records for his applications to the Intersocietal Commission for Accreditation of Echocardiography Laboratories (ICAEL) and the Intersocietal Commission for Accreditation of Nuclear Laboratories (ICANL). If this testimony is true, Respondent's revision of medical records is contrary to accepted medical practice designed to safeguard the integrity of such records, particularly here where the revised records do not indicate that they are revisions or on the date on which they were prepared. The Hearing Committee considered this to be further evidence of Respondent's lack of integrity and lack of credibility.

When it was pointed out at the hearing that Respondent failed to document any blood pressure measurements during the nuclear stress tests administered to Patient A B, D, E, F and G, he attempted to explain this failure by testifying that he wrote these blood pressures down on either the EKG tracings or separate small worksheets which were not included in the medical records submitted to the Department. The Hearing Committee did not find this explanation credible and determined that the exhibits which Respondent subsequently offered at the hearing were falsely created to support his fabricated explanation.

Respondent attempted to justify his false billing for Patient D by testifying that he had two cardiac patients with the same name of similar age and build who both visited his office on the very

same two days of January 10, 2005 and February 24, 2005. (T. 638-644, 657-661). The Hearing Committee did not believe Respondent's testimony related to having two similar patients with the same name, seen coincidentally on two subsequent dates.

The Hearing Committee then considered the credibility of the expert witnesses called by the Department and the Respondent and the weight to be accorded their testimony.

The Department's expert, Steven R. Bergmann, M.D., PhD., is currently the Chief of Cardiology for the Beth Israel Medical Center in New York, New York. His re-certifications for Internal Medicine and Nuclear Cardiology are in progress. Dr. Bergmann conducts research, maintains an active clinical practice and supervises medical students, residents and fellows. He received a medical degree from Washington University School of Medicine in St. Louis, Missouri, in 1986, and a PhD., in Physiology and Biophysics from Hahnemann Medical College in Philadelphia, Pennsylvania in 1978.

Respondent's expert, Robert M. Siegel, M.D., received his medical degree in 2003 from the Albert Einstein College of Medicine and became an Assistant Professor of Medicine there in 2010, as well as an attending cardiologist at the Jacobi Medical Center in the Bronx, New York. He is boarded in Internal Medicine, Cardiology and Nuclear Cardiology.

The Hearing Committee found that Dr. Bergmann was very knowledgeable and extremely forthright in his testimony. Accordingly, they placed great weight on his testimony. The Hearing Committee felt that Dr. Siegel had a reasonable knowledge of cardiovascular medicine, but had far less knowledge and experience than Dr. Bergmann and so accorded less weight to his testimony. Dr. Siegel generally agreed with the standards of care in cardiology as articulated by Dr. Bergmann, and he acknowledged that the patients' medical records, at times, did not contain enough information to determine whether certain diagnostic tests and treatment protocols were appropriate for the patients. (T. 769, 771, 796-797). At other times, however, Dr. Siegel's testimony was so evasive that it became

disingenuous. For example, when asked whether Respondent should have formulated a differential diagnosis for a patient, Dr. Siegel digressed into a lengthy explanation in which ultimately testified that a cardiologist has to have a differential diagnosis in the back of his head, but that he does not need to write it down (T. 764-765). The Hearing Committee specifically rejects this testimony and accepts instead the testimony of Dr. Bergmann which establishes the importance of formulating a differential diagnosis. In particular, the Hearing Committee accepts Dr. Bergmann's overall assessment of Respondent's care and treatment of these seven patients which showed:

> A pattern of listing symptoms without really developing a clear history about these symptoms just for the indication of doing tests and repeated tests almost on an annual basis and almost on the anniversary date for many of these patients. There is a pattern of doing submaximal non-diagnostic tests. There is a pattern of no diagnostic plan, no treatment plan in terms of medication, ...very minimal clinical examinations and I think not accurate measurements of even blood pressure in the office, and I don't think that Dr. Wijetilaka used standard of care for a physician. I think that his patients have suffered including patients who've come back tens of times with the same complaints without treatment. (T. 343).

Based upon its determination related to the credibility of the testimony and the documentary evidence presented, the Hearing Committee voted unanimously to sustain each and every factual allegation contained in the Amended Statement of Charges.

Specifications

The First Specification charged Respondent with professional misconduct for practicing medicine with gross negligence in his care of Patient A, in violation of New York Education Law §6530(4). Gross negligence is defined as negligence which involves a serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient. The Department established by a preponderance of the evidence that Respondent's care of Patient A was grossly negligent. The Committee Members fully concur with Dr. Bergmann's opinion that

Respondent's failure to monitor the patient's abdominal aortic aneurism placed the patient in grave risk of harm which was realized when the aneurism ruptured and the patient died. Respondent had repeated opportunities over the course of the years to attend to this critical issue as the patient returned to his office fifteen times over a three and a half year period, complaining frequently of shortness of breath. Instead, Respondent never instituted a treatment plan for the patient's shortness of breath, failed to measure and control Patient A's blood pressure and failed to address the patient's aneurism.

The Second Specification charged Respondent with professional misconduct for practicing medicine with negligence on more than one occasion in his care of Patients A through G, in violation of New York Education Law §6530(3). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances and involves a deviation from acceptable medical standards in the treatment of patients. As discussed above, the Department established by a preponderance of the evidence that Respondent's practice of medicine showed a pattern of failing to provide a course of treatment for these patients who returned over the course of year for repeated and oftentimes non-diagnostic tests. Accordingly, the Second Specification is sustained.

The Third Specification charged Respondent with professional misconduct for practicing medicine with incompetence in his care of Patient A through G, in violation of New York Education Law §6530(5). Incompetence is a lack of the skill or knowledge necessary to practice the profession. The Department established by a preponderance of the evidence that Respondent lacked even the basic requisite knowledge of the critical importance of developing a differential diagnosis for his patients. Therefore, the Third Specification is sustained.

The Fourth through Eighth Specifications charged Respondent with professional misconduct for ordering excessive tests for Patient B, D, E, F and G which were not warranted by the

condition of those patients in violation of New York Education Law §6530(35). As indicated in the findings of fact above, Respondent repeatedly administered tests on Patient B, D, E, F and G which were either non-diagnostic or normal, and Respondent frequently demonstrated no attempt to adjust his treatment to take into consideration the results of those tests. Accordingly, these Specifications are sustained.

The Ninth through Twentieth Specifications charged Respondent with professional misconduct for practicing medicine fraudulently in regard to Patients A, B, D, E, F, G in violation of New York Education Law §6530(2). Fraudulent practice is the intentional misrepresentation misrepresentation or concealment of a known fact. As indicated above in the findings of fact, Respondent misrepresented his treatment of these seven patients by altering their medical records to conceal his deficient medical care or to justify his false medical billing. The Committee infers Respondent's knowledge of the falsity of these records and his intent to deceive based on Respondent's pattern of administering tests with no regard for the results achieved as well as his inconsistent testimony regarding his production and alteration of the patient records submitted at the hearing. As such these Specifications are sustained.

The Twenty-First through Thirty-Second Specifications charged Respondent with professional misconduct for filing a false report in regard to Patient A, B, D, E, F and G, in violation of New York Education Law §6530(21). As discussed above, the Hearing Committee determined that the Department established by a preponderance of evidence that Respondent altered the patients' medical records and submitted false documents asserting they were part of the patients' medical records. Accordingly, these Specifications are sustained.

The Thirty-Third through Forty-First Specifications charged Respondent with failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient,

in violation of New York Education Law §6530(32). As discussed above, the Department established by a preponderance of the evidence that Respondent failed to take adequate histories of his patients or document an adequate treatment plan. As such these Specifications are also sustained.

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 revoked and that a civil penalty should be assessed. This determination was reached upon due consideration of the full spectrum of penalties available pursuant to statute, including revocation, suspension, probation, censure, and the imposition of civil penalties.

The Hearing Committee sustained the charge of gross negligence in Respondent's care of Patient A. Among other deficiencies, Respondent failed to monitor Patient A's abdominal aortic aneurysm over a period of three years, failed to appropriately treat the patient's blood pressure, and failed to recognize or address the critical report of the patient having collapsed, complaining of lower abdominal pain. The record also establishes Respondent's negligence and incompetence in that he followed a pattern of seeing Patient A and the other six patients over a course of years and ordering various tests, yet failing to obtain adequate histories or implementing appropriate treatment plans. The Hearing Committee believes that Respondent's failure to provide his patients with even some minimal level of medical care and consideration of the outcome of the tests which he administered demonstrates that Respondent's sole motivation for seeing patients was his own financial benefit and that he had no regard for his patients' well-being. The egregious nature of Respondent's deficient medical care

standing alone would warrant the revocation of his license to practice medicine in the State of New York.

The Hearing Committee further found that Respondent was guilty of professional misconduct in that he performed multiple diagnostic tests which were not warranted by the patients' medical conditions and that he billed for diagnostic tests which he did not perform. The Committee rejected Respondent's various explanations for his conduct and determined that a civil penalty of $50,000 should be imposed.

Finally, the Hearing Committee concluded that Respondent lacks any integrity as further evidenced by his alteration of the patients' medical records, his submission of altered records during the hearing, and his inconsistent and evolving attempts to explain his misconduct. Physicians must comply with the highest ethical standards, and integrity is as important to the practice of medicine as medical competence. The Hearing Committee found that Respondent lacked credibility, showed no remorse for his misconduct and failed to take any responsibility for his actions.

ORDER

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

1. The First through Forty-first Specifications of professional misconduct, as set forth in the Statement of Charges are SUSTAINED;

2. Respondent's license to practice medicine in the State of New York is REVOKED.

3. A civil penalty of $50,000.00 is assessed which is payable within sixty (60) days of the effective date of this Order.

4. Any civil penalty not paid by that date shall be subject to all provisions of law relating to debt collection by the State of New York. 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. Payments must be submitted to:

Bureau of Accounts Management
New York State Department of Health
Empire State Plaza
Corning Tower, Room 1717
Albany, New York 12237

5. This Determination and Order shall be effective upon service. Service shall be either by certified mail upon Respondent at his last known address and such service shall be effective upon receipt or seven days after mailing, whichever is earlier, or by personal service and such service shall be effective upon receipt.

DATED: New York, New York
June 21, 2012

REDACTED

MICHAEL R. GOLDING, M.D. (CHAIR)

REID T. MULLER, M.D.
JOAN MARTINEZ-McNICHOLAS

TO: Christine Radman, Esq.
Associate Counsel
New York State Department of Health
Office of Professional Medical Conduct
90 Church Street
New York, New York 10007

William L. Wood, Esq.
Wood & Scher
Attorney for Respondent
222 Bloomindale Road
White Plains, New York 10605

APPENDIX I

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

IN THE MATTER

OF

ROHAN WIJETILAKA, M.D.

NOTICE

OF

HEARING

TO: ROHAN WIJETILAKA
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 December 15, 2011, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 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
November 10, 2011

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Chrsitine M. Radman
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street
New York, New York 10007
2124174450

EXHIBIT

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

IN THE MATTER

OF

ROHAN WIJETILAKA, M.D.

AMENDED STATEMENT OF CHARGES

ROHAN WIJETILAKA, M.D., the Respondent, was authorized to practice medicine in New York State on or about August 30, 1993, by the issuance of license number 193531 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. During the period between on or about April 9, 1999 through January 16, 2003, Respondent was Patient A's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:

1. Failed to adequately take histories and perform clinical exams.
2. Failed to adequately perform differential diagnoses for Patient A's complaints of, including but not limited to, shortness of breath, chest pain, palpitations and dizziness.
3. Failed to use and/or inappropriately used diagnostic testing.
4. Failed to implement proper treatment protocols.
5. Failed to adequately and appropriately follow Patient A's abdominal aortic aneurysm.
6. Failed to maintain a record for Patient A which accurately reflected his care and treatment.
7. Falsely reported findings of abdominal ultrasounds that he did not

perform.

a. Respondent did so with an intent to deceive.

8. Submitted false records for Patient A to The Department of Health after service of the Statement of Charges in this proceeding.

a. Respondent did so with an intent to deceive.

Amended 1/24/12

B. During the period between on or about March 1, 2004 through on or about April 22, 2005, Respondent was Patient B's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:

1. Failed to adequately take histories and perform clinical exams.
2. Failed to adequately perform differential diagnoses for Patient B's complaints of dizziness and/or shortness of breath.
3. Performed diagnostic tests not warranted by Patient B's condition.
4. Failed to properly administer diagnostic cardiac tests.
5. Failed to implement appropriate treatment protocols.
6. Failed to maintain a record for Patient B which accurately reflected his care and treatment.
7. Submitted false records for Patient B to The Department of Health after service of the Statement of Charges in this proceeding.

a. Respondent did so with an intent to deceive.

C. On or about May 29, 2002, March 30, 2005 and January 29, 2006, Patient C was admitted to St. John's Riverside Hospital (SJRH) in Yonkers, New York. Respondent was the cardiologist involved in her care and treatment and deviated from minimally acceptable standards of care in that he:

1. For the May 29, 2002 admission for suspected heart failure:

a. Failed to adequately monitor Patient C after her documented

episodes of ventricular tachycardia.

b. Failed to provide an adequate clinical plan and/or note for Patient C's transfer to another hospital.

2. For the March 30, 2005 admission for chest pain:

a. Failed to address diagnostic test results, including but not limited to Patient C's EKG and cardiac enzymes, severely elevated hemoglobin A1C, low potassium and high blood glucose levels.

b. Failed to include a follow-up plan on Patient C's discharge summary.

c. Failed to provide an adequate clinical plan and/or note for Patient C's transfer to another hospital.

3. For the January 29, 2006 admission for a syncopal episode:

a. Failed to include a report of Patient C's arrhythmia in her chart.

b. Failed to address diagnostic test results, including but not limited to Patient C's EKG and blood chemistry.

c. Failed to include a follow-up plan on Patient C's discharge summary.

D. During the period between on or about May 5, 2003 through on or about August 6, 2005, Respondent was Patient D's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:

1. Failed to adequately take histories and perform clinical exams.

2. Failed to adequately perform differential diagnoses for Patient D's complaints of chest pain, dizziness, shortness of breath and/or syncope.

3. Performed diagnostic tests not warranted by Patient D's condition.

4. Failed to properly administer diagnostic cardiac tests.
5. Failed to implement appropriate treatment protocols.
6. Failed to maintain a record for Patient D which accurately reflected his care and treatment.
7. Purportedly performed, but in fact did not perform yet billed for diagnostic testing, including but not limited to nuclear stress testing on January 17, 2005 and/or holter monitoring on February 23, 2005, for which no documentation nor reports are present within Patient D's medical record.
   a. Respondent did so with an intent to deceive.
8. Submitted false records for Patient D to The Department of Health after service of the Statement of Charges in this proceeding.
   a. Respondent did so with an intent to deceive.

E. During the period between on or about July 21, 2000 through on or about October 10, 2005, Respondent was Patient E's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:
1. Failed to adequately take histories and perform clinical exams.
2. Failed to adequately perform differential diagnoses for Patient E's complaints of chest pain, shortness of breath, palpitations and/or dizziness.
3. Performed diagnostic tests not warranted by Patient E's condition.
4. Failed to properly administer diagnostic cardiac tests.
5. Failed to implement appropriate treatment protocols.
6. Failed to maintain a record for Patient E which accurately reflected his care and treatment.
7. Purportedly performed, but in fact did not perform yet billed for

diagnostic testing, including but not limited to a stress echocardiogram on November 2, 2001, an abdominal aortic ultrasound on March 8, 2004 and other echocardiograms and ultrasounds dated from August 8, 2000 through July 15, 2005 , for which no documentation nor reports are present within Patient E's medical record.

a. Respondent did so with an intent to deceive.

8. Submitted false records for Patient E to The Department of Health after service of the Statement of Charges in this proceeding.

a. Respondent did so with an intent to deceive.

F. During the period between on or about January 14, 2005 through on or about October 19, 2005, Respondent was Patient F's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:

1. Failed to adequately take histories and perform clinical exams.
2. Failed to adequately perform differential diagnoses for Patient F's complaints of chest pain, shortness of breath, palpitations and/or dizziness.
3. Performed diagnostic tests not warranted by Patient F's condition.
4. Failed to properly administer diagnostic cardiac tests.
5. Failed to implement appropriate treatment protocols.
6. Failed to maintain a record for Patient F which accurately reflected his care and treatment.
7. Purportedly performed, but in fact did not perform yet billed for diagnostic testing, including but not limited to a stress echocardiogram on January 19, 2005 and/or an aortic scan and arterial ultrasound on July 20, 2005, for which no documentation nor reports are present within Patient F's medical record.

a. Respondent did so with an intent to deceive.

8. Billed Empire Blue Cross/Blue Shield for a nuclear stress test on January 19, 2005 but performed no test, if any, that day with a nuclear component.

   a. Respondent did so with an intent to deceive.

9. Submitted false records for Patient F to The Department of Health after service of the Statement of Charges in this proceeding.

   a. Respondent did so with an intent to deceive.

G. During the period between on or about March 7, 2001 through on or about September 22, 2005, Respondent was Patient G's cardiologist. Respondent deviated from minimally acceptable standards of care in that he:

1. Failed to adequately take histories and perform clinical exams.
2. Failed to adequately perform differential diagnoses for Patient G's complaints of chest pain, shortness of breath, and/or dizziness.
3. Performed diagnostic tests not warranted by Patient G's condition.
4. Failed to properly administer diagnostic cardiac tests.
5. Failed to implement appropriate treatment protocols.
6. Failed to maintain a record for Patient G which accurately reflected his care and treatment.
7. Billed Medicare Part B for a nuclear stress test on April 1, 2005 but performed no test, if any, that day with a nuclear component.

   a. Respondent did so with an intent to deceive.

8. Submitted false records for Patient G to The Department of Health after service of the Statement of Charges in this proceeding.

   a. Respondent did so with an intent to deceive.

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. Paragraph A and each of its subparagraphs, except A(7)(a) and A(8) and A(8)(a).

SECOND 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:

2. Paragraph A and each of its subparagraphs except A(7)(a), A(8) and A(8)(a), Paragraph B and each of its subparagraphs except B(7) and B(7)(a), Paragraph C and each of its subparagraphs, Paragraph D and each of its subparagraphs, except D(7)(a), D(8) and D(8)(a), Paragraph E and each of its subparagraphs, except E(7)(a), E(8) and E(8)(a), Paragraph F and each of its subparagraphs, except F(7)(a), F(8) and F(8)(a), F(9) and F(9)(a) and Paragraph G and each of its subparagraphs, except G(7), G(7)(a), G(8) and G(8)(a).

THIRD 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:

3. Paragraph A and each of its subparagraphs except A(7)(a), A(8) and A(8)(a), Paragraph B and each of its subparagraphs except B(7) and B(7)(a), Paragraph C and each of its subparagraphs, Paragraph D and each of its subparagraphs, except D(7)(a), D(8) and D(8)(a), Paragraph E and each of its subparagraphs, except E(7)(a), E(8) and E(8)(a), Paragraph F and each of its subparagraphs, except F(7)(a), F(8) and F(8)(a), F(9) and F(9)(a) and Paragraph G and each of its subparagraphs, except G(7), G(7)(a), G(8) and G(8)(a).

FOURTH THROUGH EIGHTH SPECIFICATIONS

UNWARRANTED TESTS/TREATMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(35) by ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient, as alleged in the facts of:

4. Paragraphs B and B(3).
5. Paragraphs D and D(3).
6. Paragraphs E and E(3).
7. Paragraphs F and F(3).
8. Paragraphs G and G(3).

NINTH THROUGH TWENTIETH SPECIFICATIONS

FRAUDULENT PRACTICE

Respondent is charged with committing professional misconduct as defined by N.Y. Educ. Law § 6530(2) by practicing the profession of medicine fraudulently as alleged in the facts of the following:

9. Paragraphs A, A(7) and A(7)(a),
10. Paragraphs A, A(8) and A(8)(a).
11. Paragraphs B, B(7) and B(7)(a).
12. Paragraphs D, D(7) and D(7)(a).
13. Paragraphs D, D(8) and D(8)(a).
14. Paragraphs E, E(7)and E(7)(a)
15. Paragraphs E, E(8)and E(8)(a).
16. Paragraphs F, F(7) and F(7)(a)
17. Paragraphs F, F(8) and F(8)(a).
18. Paragraphs F, F(9) and F(9)(a).
19. Paragraphs G, G(7) and G(7)(a)
20. Paragraphs G, G(8) and G(8)(a).

TWENTY-FIRST THROUGH THIRTY-SECOND SPECIFICATIONS

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by wilfully making or filing a false report, or failing to file a report required by law or by the department of health or the education department, as alleged in the facts of:

21. Paragraphs A and A(7).
22. Paragraphs A and A(8).
23. Paragraphs B and B(7).
24. Paragraphs D and D(7).
25. Paragraphs D and D(8).

26. Paragraphs E and E(7).

27. Paragraphs E and E(8).

28. Paragraphs F and F(7).

29. Paragraphs F and F(8).

30. Paragraphs F and F(9).

31. Paragraphs G and G(7).

32. Paragraphs G and G(8).

THIRTY-THIRD THROUGH FORTY-FIRST SPECIFICATIONS

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:

33. Paragraphs A and A(6).

34. Paragraphs B and B(6).

35. Paragraphs C and C(1)(b).

36. Paragraphs C, C(2)(b) and C(2)(c).

37. Paragraphs C and C(3)(c).

38. Paragraphs D and D(6).

39. Paragraphs E and E(6)

40. Paragraphs F and F(6)

41. Paragraphs G and G(6)

DATE: November 10, 2011
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct