Public

STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299
www.health.ny.gov

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

Sue Kelly
Executive Deputy Commissioner

March 18, 2011

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Lopez, M.D.

REDACTED

Jonathan A. Bath, Esq.
Pilkington & Leggett, P.C.
222 Bloomingdale Road
White Plains, New York 10605

Joel E. Abelove, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237-0032

RE: In the Matter of Daniel Lopez, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 11-67) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

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

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

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

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

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

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

Sincerely,

REDACTED

James F. Horan, Acting Director
Bureau of Adjudication

JFH:cah

Enclosure

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

IN THE MATTER

OF

DANIEL LOPEZ, MD

DETERMINATION

AND

ORDER

BPMC #11-67

COPY

A Notice of Hearing and Statement of Charges were served upon the Respondent **DANIEL LOPEZ, M.D.** Chairperson **IRVING CAPLAN, DIANE SIXSMITH M.D.**[1], and **WILLIAM TEDESCO M.D.** duly designated members of the State Board of Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. Administrative Law Judge **KIMBERLY A. O'BRIEN ESQ.** served as the Administrative Officer.

The Department of Health appeared by THOMAS CONWAY ESQ., General Counsel, by **JOEL ABELOVE**, of Counsel. The Respondent **DANIEL LOPEZ, M.D.** appeared in person and by Counsel **JONATHAN A. BATH ESQ.**

Evidence was received and argument heard, and transcripts of these proceedings were made. After consideration of the entire record, the Hearing Committee issues this Determination and Order.

STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York.

[1] The Administrative Law Judge and the parties were notified that Dr. Alexander Kuehl's (original hearing panel member) residency status had changed and without objection Dr. Diane Sixsmith was appointed to replace Dr. Kuehl on the hearing panel (*See* ALJ Ex. 2).

This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. Daniel Lopez M.D. (hereinafter "Respondent") is charged with five specifications of misconduct including: negligence, gross negligence, incompetence, gross incompetence and failure to maintain a patient record all as set forth in Section 6530 of the Education Law of the State of New York (hereinafter "Education Law"). Respondent admits treating patients A-G[2] in the emergency department ("hereinafter "emergency department" or "ED") of various hospitals, however, denies the first through the fifth specifications of misconduct set forth in the Statement of Charges. Specifically, Respondent denies any and all factual allegations and specifications regarding patients A through G (Ex. A). Respondent requests that all factual allegations and the five specifications of misconduct set forth in the Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix 1, be dismissed in their entirety.

PROCEDURAL HISTORY

Notice of Hearing & Statement of Charges	March 18, 2010 & March 17, 2010
Respondent's Answer	April 5, 2010
Hearing Dates	April 20&21, 2010; May 25, 2010; June 22 & 23, 2010; September 29&30, 2010; and November 30, 2010 & December 1, 2010
Witnesses for Petitioner	Dan Mayer M.D., Carol Janicki R.N.
Witnesses for Respondent	Daniel Lopez M.D. Anthony Mustalish M.D.
Final Hearing Transcript Received	December 13. 2010

[2] Respondent denies seeing Patient G, however, admits reviewing an EKG for Patient G and that direct care and treatment was provided by other emergency room personnel (*See* Ex. A "ANSWER TO THE STATEMENT OF CHARGES"; *See also* Tr. 917-922).

Parties Briefs January 10, 2011

Deliberations Date January 24, 2011

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 ("Hearing Committee" or "Committee"). Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. Numbers below in parentheses refer to exhibits (denoted by the prefix "Ex.") or transcript page numbers ("Tr."). These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding.

Having heard argument and considered the documentary evidence presented, the Hearing Committee hereby makes the following findings of fact:

1. On or about September 14, 1993, Respondent DANIEL LOPEZ, M.D., was authorized to practice medicine in New York State, by the issuance of license number 193650 (Ex. 3). Respondent is an emergency room physician who provided care to patient's A through G (Ex. 1 & Ex. A).

PATIENT A

2. On February 23, 2007, Patient A a 48-year-old man presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York, with a right middle finger injury sustained in a fight during a hockey match (Ex.4).

3. Respondent took a patient history, diagnosed the dislocated finger, reduced the dislocation and provided discharge instructions to Patient A (Ex. 4, 21 &22; Tr. 963-970).

PATIENT B

4. On February 26, 2003, Patient B a 19-year-old male with a history of diabetes presented to the Emergency Department at Horton Medical Center, Middletown, New York, by ambulance, and he had been ill for three days (Ex.7).

5. Upon arrival at the emergency department Patient B was conscious, had an elevated glucose level and abnormal vital signs. Respondent ordered blood tests, administered IV fluids, assessed test results and consulted with a critical care physician all within 90 minutes of Patient B's arrival at the hospital (Ex.7; Tr. 998-1007).

PATIENT C

6. October 21, 2003, Patient C a 32-year-old female presented to the Emergency Department at New York Westchester Square Medical Center, Bronx, New York with complaints of left temporal headache for the past two days and seeing spots in front of her eyes (Ex.8).

7. Respondent obtained a patient history, ordered a CT scan, and assessed vital signs and condition before discharging Patient C with instructions for follow up care (Ex. 8; Tr.1036-1047).

PATIENT D

8. October 4, 2004, Patient D a 61-year-old male presented to the Emergency Department at St. Luke's Cornwall Hospital, Newburgh, New York with complaints of back, right knee and heel pain, and shortness of breath, all after falling 10 feet off of a ladder the day before (Ex. 9).

9. Respondent took a patient history, conducted a physical examination and ordered tests, however, he did not accurately read the x-ray missing the fracture of Patient D's sixth thoracic vertebra and order a CT scan (Ex. 9 &23; Tr. 267, 282, 286, 791, 1088, 1093).

PATIENT E

10. On or about January 28, 2006, Patient E a 94 year-old female presented to the Emergency Department at Mercy Hospital Buffalo, Buffalo New York complaining of sharp chest wall pain that worsened when she coughed (Ex. 10).

11. Respondent after receiving abnormal laboratory test results for Patient E that included elevated Troponin, did not order additional testing and evaluation for Patient E (Ex. 10; Tr. 356-362, 840 & 843).

12. Respondent diagnosed Patient E as having costochondritis and did not provide appropriate discharge instructions to Patient E (Ex. 10; Tr. 357-358; 364-365, 851- 852).

PATIENT F

13. On December 7, 2006, at approximately 7:03 p.m., Patient F a 61-year-old male presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York complaining of a sore throat and difficulty swallowing liquids (Ex. 11b)

14. Respondent did not interpret epiglottitis on the neck x-ray of Patient F or consult with a specialist (Ex. 11b & 24; Tr. 463-464, 467, 904-905 &1215).

PATIENT G

15. On December 4, 2005, Patient G a 31-year-old male presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York by ambulance with complaints of chest pain for five hours (Ex. 12).

16. Respondent reviewed Patient G's initial EKG, additional EKGs were done in the emergency department and the patient was sent to the "Cath lab" (Ex. 12; Tr. 919-922).

DISCUSSION & CONCLUSIONS

The Hearing Committee's conclusions were unanimous and based on the entirety of the record including testimony of the Department and Respondent's witnesses, and the documentary evidence

introduced at the hearing. The Department has the burden of proof and must establish by a preponderance of evidence that the Respondent is guilty as charged. The Committee made a credibility determination about the witnesses and found both the Department and Respondent's expert, and Respondent himself to be credible. The Department's expert Dr. Dan Mayer and Respondent's expert Dr. Anthony Mustalish are both board certified in emergency medicine and practicing emergency room physicians with experience teaching emergency medicine. Overall both expert witnesses were found to be well qualified by education, training, and experience to render an opinion about the standards of care in this case. However, the Committee also found that in some instances described herein, each expert reached too far in their respective position in criticizing or defending the care Respondent provided to patients A through G. The Committee found the Respondent to be open and honest about the care he provided to these seven patients and throughout his testimony showed a genuine interest in improving his practice. The following is a discussion of the Committee's findings and conclusions regarding each patient.

Patient A

The Department charged Respondent with multiple deviations from the standard of care regarding his care and treatment of Patient A including failure to adequately document injury, identify a fracture in the pre-reduction x-ray, and obtain a post reduction x-ray. Respondent treated Patient A, a 48-year-old man who presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York with a right middle finger injury sustained in a fight during a hockey match. Dr. Mustalish testified that Respondent took an adequate history, correctly diagnosed the dislocated finger, reduced the dislocation and provided appropriate discharge instructions. He stated that the "fracture" as seen on the pre-reduction x-ray was not clinically significant and a post reduction x-ray was not necessary, and would not have changed the course of treatment or the discharge instructions. Even Dr. Mayer agreed

that a post reduction x-ray "is not always necessary" and provided little to support his position that Respondent's care of this patient failed to meet the standard of care. The Hearing Committee found that the medical record along with the testimony of Dr. Mustalish established that Respondent provided appropriate care and treatment to Patient A.

Patient B

The Department charged Respondent with failure to meet the standard of care in his treatment of Patient B alleging that upon Patient B's arrival to the emergency department, Respondent should have immediately performed a "finger stick" glucose level check, administered insulin, and consulted with an internist or critical care physician. Patient B a 19-year-old male with a history of diabetes who had been ill for three days presented to the Emergency Department at Horton Medical Center, Middletown, New York, by ambulance. Upon arrival at the emergency department Patient B was conscious, had an elevated glucose level (glucose level test performed en route to the hospital) and abnormal vital signs. Dr. Mayer testified that if Respondent had immediately performed a "finger stick" glucose test and consulted a critical care specialist the patient may not have expired, however, he did not meaningfully distinguish how the care Respondent provided failed to meet the standard of care. Dr. Mustalish provided detailed testimony about the care Respondent provided here. He used the patient record to illustrate that Respondent met the standard of care by ordering blood tests, administering IV fluids, assessing test results and consulting with a critical care physician all within 90 minutes of Patient B's arrival at the hospital. Based on the foregoing, the Committee found Respondent met the standard of care in his treatment of Patient B.

Patient C

The Department charged the Respondent with failing to: obtain a sufficient history of Patient C's headache, assess patient complaint of seeing spots in front of her eyes, perform a fundoscopic exam,

consider pseudotumor cerebri as a possible diagnosis, and take vital signs before discharging the patient. Patient C a 32-year-old female presented to the Emergency Department at New York Westchester Square Medical Center, Bronx, New York with complaints of left temporal headache for the past two days and seeing spots in front of her eyes. Dr. Mayer testified that given the patient presentation the Respondent should have among other things performed a fundoscopic examination, ordered a spinal tap and considered the diagnosis of pseudotumor cerebri. Dr. Mustalish testified that pseudotumor cerebri is a relatively rare condition and Respondent treated the patient appropriately including: obtaining a patient history, ordering a CT scan, and assessing vital signs and condition before discharging Patient C with instructions for follow up care. The Committee found based on Dr. Mustalish's testimony and the record that Respondent met the standard of care in his treatment of Patient C.

Patient D

The Department charged the Respondent with failing to take an adequate history and noting an "abrasion" only in his diagnosis, assess the spine and appreciate tenderness, order a CT and C-spine x-ray, perform a rectal exam, and recognize and diagnose a compression fracture of Patient D's sixth thoracic vertebra. Patient D a 61-year-old male presented to the Emergency Department at St. Luke's Cornwall Hospital, Newburgh, New York, with complaints of back, right knee and heel pain, and shortness of breath, all after falling 10 feet off of a ladder the day before. Dr. Mayer testified that the foregoing allegations are true and that the x-ray shows an obvious fracture. Dr. Mustalish testified that the patient history (including that the patient ambulated into the ED), physical exam and testing were all adequate, and he could see a "wedge" on the x-ray, which indicates a compression fracture. Dr. Mustalish's testimony and the record lead the Committee to find that Respondent obtained an adequate history and physical examination. However, the expert testimony of Dr. Mayer and Dr.

Mustalish along with the patient x-ray lead the Committee to find that Respondent failed to diagnose a fracture of the patient's sixth thoracic vertebra and order a CT scan.

Patient E

The Department charged Respondent with multiple deviations from the standard of care including failing to follow up on Patient E's elevated BUN and Troponin levels and admit the patient to the hospital. The Department also charged Respondent with failing to properly diagnose the patient and based on the wrong diagnosis failed to provide proper discharge instructions. Patient E a 94-year-old female presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York, with complaints of sharp chest wall pain for the past two days, and left chest wall pain that worsened when she coughed. Dr. Mayer testified that given the age, history and initial test results the patient should have been admitted to the hospital. In his opinion, Respondent not only misdiagnosed the patient he failed to provide adequate discharge instructions based on his diagnosis. Dr. Mustalish testified that based on the patient's test results, history and physical he himself would not have admitted the patient to the hospital. While Dr. Mustalish acknowledged that the record does not include written discharge instructions for the patient to follow–up with her private physician, he asserted that Respondent might have provided verbal discharge instructions to the patient. Based on the testimony and the record, the Committee concluded that Respondent's patient care decisions were supported by his interaction with Patient E; however, the overall quality of care was diminished by Respondent's careless charting practices. Respondent's lack of attention to detail could not be ignored by the Committee and they found that the Respondent did not provide appropriate discharge instructions to Patient E.

Patient F

The Department charged Respondent with putting the patient at risk by failing to take a soft tissue x-ray on the patient's first visit to the E.D., accurately interpret the x-ray on the second visit, order

a CT scan, and consult a specialist. Patient F a 61-year-old male presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York, with complaints of a sore throat for three days and a left earache since the previous night. Patient F was initially diagnosed with viral pharyngitis and was discharged home. Later in the day he returned to the emergency department with complaints of an extremely sore throat and difficulty swallowing liquids. Dr. Mayer testified that the patient's complaints upon his return to the ED and the x-ray clearly indicate epiglottitis and a CT scan should have been ordered. Dr. Mustalish testified that he could recognize epiglottitis on the x-ray. Based on the expert testimony and the record, the Committee found that the Respondent failed to accurately interpret Patient E's neck x-ray and based on this failure did not order a CT scan.

Patient G

The Department alleged that Respondent did not determine that Patient G's initial EKG was abnormal because he believed "tombstone changes" were required to show an abnormal EKG and failed to provide appropriate care to the patient based on that belief. Patient G a 31-year-old male presented to the Emergency Department at Mercy Hospital of Buffalo, Buffalo, New York by ambulance with complaints of chest pain for five hours. Respondent testified that he never actually saw Patient G, as he was caring for a critically ill patient; however, he did review Patient G's initial EKG and directed that the patient receive cardiac care. The record reflects that after Respondent read the initial EKG, additional EKGs were done in the emergency department and the patient was sent to the Cath lab for additional testing and treatment. The Hearing Committee accepted Respondent's hearing testimony that he had no contact with Patient G and does not believe that an abnormal EKG requires "tombstone" changes. The medical record supports Respondent's position as it clearly shows that

additional EKGs were performed and Patient G was sent to the "Cath lab" as per protocols. Based on the forgoing the Committee found that Respondent met the standard of care here.

The Hearing Committee sustained the factual allegations in Paragraph D.4&D.6; E.2&E.7; F.2 & F.3 and the First Specification set forth in the Statement of Charges and found based on a preponderance of the evidence that Respondent's care with respect to Patient D, Patient E and Patient F constitutes negligence on more than one occasion pursuant to Education Law Section 6530(3) (Ex. 1). Negligence is defined as the failure to exercise the care that would be exercised by a reasonably prudent licensee under the circumstances (ALJ Ex. 1A "Definitions of Professional Misconduct-Greenberg Memorandum").

The Hearing Committee did not sustain the Factual Allegations in Paragraph A.1, A.2, A.3, A.4 & A.5; B.1&B.2; C.1, C.2, C.3, C.4&C.5; D.1, D.2, D.3, D.5&D.7; E.1, E.3, E.4, E.5&E.6; F.1&F.4; G.1 and the Second, Third, Fourth and Fifth Specifications of Misconduct set forth in the Statement of Charges that specifically relate to gross negligence; incompetence on more than one occasion; gross incompetence and failure to maintain medical records that accurately reflect the care and treatment of a patient (Ex.1, *See* Education Law Sections 6530(4), 6530(5), 6530(6) &6530(32); *See also* ALJ Ex. 1A "Definitions of Professional Misconduct-Greenberg Memorandum"). The Hearing Committee concluded that Respondent adequately treated Patients A, B, C and G, and the findings of negligence regarding Patient's D, E & F when considered alone or in sum did not meet the definition of gross negligence which is defined as an egregious, serious or significant deviation from acceptable medical standards that creates the risk of potentially grave consequences to the patient (Education Law Section 6530(4); *See* ALJ Ex. 1A).

Further, in order to sustain findings of incompetence and /or gross incompetence there must be strong credible evidence presented that the Respondent lacks the requisite skill or knowledge necessary to practice the profession (Education Law Section 6530(5) & 6530(6); *See* Ex. ALJ 1A). The Department failed to show that the Respondent was incompetent and therefore the Committee did not sustain any of the allegations of simple and/or egregious act(s) of incompetence.

Finally, Respondent was charged with failing to maintain a medical record that accurately reflects the care and treatment of Patient A, Patient C, Patient D and Patient E. While the Committee is concerned about the rigor and overall consistency of Respondent's charting practices they found that there was insufficient credible evidence to support the record keeping allegations as charged by the Department.

DETERMINATION AS TO PENALTY

When making a penalty determination, the Committee considered the nature and seriousness of the finding of misconduct in the context of the care Respondent provided to the seven patients and his testimony and demeanor throughout the proceeding. While the Committee found Respondent was negligent on more than one occasion, which resulted in less than optimal care for some of the patients, they did not find the acts of negligence were egregious. Respondent has practiced emergency medicine for more than twenty years and it was evident to the Committee that he possesses the skills and ability to practice emergency medicine. Respondent's testimony and demeanor throughout the proceeding showed the Committee that he takes responsibility for his actions and is open to improving his practice, and will benefit from a review course that includes charting and x-ray interpretation.

After due and careful consideration of the penalties available pursuant to Public Health Law Section 230-a, the Hearing Committee has determined that in order to protect the public Respondent

shall be on probation for one year and during this period successfully complete an approved Board Review Course in the Essentials of Emergency Medicine. The specific terms of probation are attached and made part of this decision and order and marked as Appendix B.

ORDER

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

1. The Factual Allegations set forth in Paragraphs D.4&D.6; E.2&E.7; F.2&F.3 and the First Specification of misconduct as set forth in the Statement of Charges (Ex.1) are **SUSTAINED;**

2. The Factual Allegations as set forth in Paragraphs A.1, A.2, A.3, A.4&A.5; B.1&B.2; C.1,C.2, C.3, C.4&C.5; D.1, D.2, D.3, D.5&D.7; E.1, E.3, E.4, E5&E.6; F.1&F.4; G.1 and Second, Third, Fourth and Fifth Specifications of Misconduct set forth in the Statement of Charges are **DISMISSED;**

3. Respondent shall be on probation for a period of one year. During the probationary period Respondent shall successfully complete a Board Review Course in the Essentials of Emergency Medicine which shall be approved by the Board of Professional Medical Conduct ("Board"). The specific terms of probation are attached and incorporated herein, and marked as Appendix B.

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

DATED: Albany, New York
3-11-11, 2011

BY: REDACTED

IRVING CAPLAN Chairperson
DIANE SIXSMITH M.D.
WILLIAM TEDESCO M.D.

Cc: Daniel Lopez M.D.
REDACTED

Jonathan A. Bath, Esq.
Pilkington & Leggett, P.C.
222 Bloomingdale Road
White Plains, New York 10605

Joel E. Abelove, Esq.
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower Room 2512
Albany, New York 12237-0032

APPENDIX B
Terms of Probation

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

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

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

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

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

6. Respondent shall enroll in and successfully complete a Board Review Course in the Essentials of Emergency Medicine. Said continuing education program shall be subject to the prior written approval of the Director of OPMC, and be completed within the period of probation.

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

8. Respondent shall maintain legible and complete medical records that accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.

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

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

APPENDIX I

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

IN THE MATTER

OF

DANIEL LOPEZ, MD

NOTICE
OF
HEARING

TO: DANIEL LOPEZ, M.D., c/o Jonathan A. Bath, Esq.
Pilkington & Leggett, P.C.
222 Bloomingdale Road
White Plains, New York 10605

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 April 20-21, 2010, at 10:00 a.m., at Hedley Park Place, 5th Floor South, 433 River Street, Troy, New York, 12180, and at such other adjourned dates, times and places as the committee may direct.

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

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. JAMES F. 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: Albany, New York
March 18, 2010

REDACTED

Peter D. Van Buren
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Joel E. Abelove
Associate Counsel
Bureau of Professional Medical Conduct
Empire State Plaza
Corning Tower - Room 2512
Albany, New York 12237-0032
(518) 473-4282

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

IN THE MATTER
OF
DANIEL LOPEZ, M.D.

STATEMENT
OF
CHARGES

DANIEL LOPEZ, M.D., Respondent, an emergency medicine physician, was authorized to practice medicine in New York State on September 14, 1993, by the issuance of license number 193650 by the New York State Education Department, with a current registration address of REDACTED

FACTUAL ALLEGATIONS

A. Respondent provided medical care to Patient A, a on February 23, 2007, at the South Buffalo Mercy Hospital Emergency Department, for an injury to Patient A's right middle finger. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Respondent failed to take a post-reduction x-ray of Patient A's right middle finger, to check for a persistent dislocation or subluxation or the presence of a fracture with the dislocation.

2. Respondent failed to document whether he or the medical resident performed the reduction of Patient A's dislocated right middle finger.

3. Respondent failed to diagnose a fracture on the pre-reduction x-ray of Patient A's right middle finger.

4. Respondent failed to clearly document how the injury occurred, the presence of a ligamentous injury, and an attending physician examination.

5. Respondent failed to document normal sensation and blood flow in Patient A's right middle finger, post-reduction.

B. Respondent provided medical care to Patient B, a 19-year-old male, on February 26, 2003, in the Horton Medical Center Emergency Department, following a syncopal episode at his home. Patient B's vital signs were seriously abnormal with a temperature of 103.4, a pulse rate of 150, a respiratory rate of 20 and a blood pressure of 94/28. Respondent made a diagnosis of diabetic coma, probably ketoacidosis. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Respondent failed to obtain an immediate finger stick glucose level on Patient B's arrival by EMS, and failed to immediately begin treatment with intravenous insulin or an insulin drip.

2. Respondent failed to obtain earlier consultations with an internist or critical care physician in order to manage Patient B, who was critically ill.

C. Respondent provided medical care to Patient C, a 32-year-old female, on October 21, 2003, at the New York Westchester Square Medical Center's Emergency Department, with complaints of left temporal headache for the past two days, and seeing spots in here eyes. Patient C was diagnosed with temporal arteritis, and treated with prednisone. Patient C was subsequently diagnosed with as having pseudotumor cerebri. Respondent's care and treatment of Patient C failed to meed accepted standards of medical care in that:

1. Respondent failed to obtain and/or document from Patient C a history

noting the rapidity with which the headache began. Respondent failed to obtain a temporal history of the headache, a history of the level of severity of the headache, or assess if there was any family history of headaches.

2. Respondent failed to conduct a fundoscopic examination.

3. Respondent failed to reassess Patient B and get his vital signs prior to discharging Patient B.

4. Respondent failed to assess the patient seeing spots in front of her eyes.

5. Respondent failed to consider the possibility of pseudotumor cerebri.

D. Respondent provided medical care to Patient D, a 61-year-old male, on October 4, 2004, at the St. Luke's Cornwall Hospital's Emergency Department, with complaints of back pain, right knee pain and right foot pain since the previous day after falling 10 feet from a ladder. Patient D was diagnosed with abrasion to the back and soft tissue injury to the right leg and heel. Patient D was discharged on October 4, 2004; however, x-rays of the back revealed a compression fracture of the T6 vertebral body which were interpreted on October 5, 2004. Respondent's care and treatment of Patient D failed to meed accepted standards of medical care in that:

1. Respondent's history was substandard in that he only asked vaguely and generally about the location of the pain. Respondent failed to ask about or document numbness and tingling of the arms or legs, any weakness, problems urinating or moving bowels.

2. Respondent failed to perform a rectal examination on Patient D as part of a complete neurological examination on a patient with spinal trauma.

3. Respondent testified in a deposition that there was an abrasion, but failed to record an abrasion on the physical examination sheet. Respondent only recorded the abrasion in his diagnosis.

4. Respondent failed to accurately read the x-ray, missing the fracture of Patient D's sixth thoracic vertebra.

5. Given the degree of fracture to Patient D's sixth thoracic vertebra, Respondent's assessment that the spine was not tender is not plausible.

6. Respondent failed to obtain a CT scan of the thoracic spine area that was fractured to determine if there were any fragments in or near the spinal canal.

7. Respondent failed to order a c-spine x-ray of Patient D.

E. Respondent provided medical care to Patient E, a 94-year-old female, on January 28, 2006, at Mercy Hospital's Emergency Department, with complaints of chest wall pain for the past two days, described as sharp, left chest wall pain that worsened when she coughed. Patient E was diagnosed with a urinary tract infection, dehydration and costochondritis. Patient E was discharged home on Levaquin 250-mg po, and to follow up with her primary care physician. Respondent's care and treatment of Patient E failed to meed accepted standards of medical care in that:

1. Respondent failed to obtain and/or document a complete history of Patient E's chest pain, and failed to perform a complete physical examination, including a rectal examination. In lieu of a rectal examination, Respondent failed to obtain old records that demonstrated that the low

hematocrit was a chronic and not acute event, or test a bowel movement for the presence of blood.

2. Respondent failed to adequately treat Patient E for abnormal laboratory tests that were discovered during the examination. Patient E had an elevated BUN and Troponin for which Respondent did not do any further evaluation work or suggest follow up.

3. Respondent failed to diagnose Patient E's anemia.

4. Respondent diagnosed Patient E with dehydration, on the basis of which is not at all clear.

5. Respondent's failure to consider the elevated Troponin level being due to a myocardial infarction, rather than a renal problem, put Patient E at risk for sudden cardiac death that could have been avoided by admitting her to the hospital on a monitored bed. Respondent should have ordered an EKG to evaluate for cardiac eschemia.

6. Respondent's decision to treat Patient E with an antibiotic was based on inadequate information since her complaint was chest pain associated with increasing pain when she coughed.

7. Respondent failed to provide discharge instructions for his diagnosis of costochondritis

F. Respondent provided medical care to Patient F, a 61-year-old male, on December 7, 2006, at 5:37 AM, at Mercy Hospital's Emergency Department, with complaints of a sore

throat (three days prior) and a left earache since the previous night. Patient F was diagnosed with viral pharyngitis and was discharged home. Patient F returned to the ED on December 7, 2006, at 7:03 PM, with complaints of sore throat for 24 hours and difficulty swallowing liquids. Patient F had epiglottitis which was missed at this visit. Respondent's care and treatment of Patient F failed to meed accepted standards of medical care in that:

1. Respondent failed to obtain a soft tissue x-ray of the neck at the first visit.

2. Respondent failed to accurately interpret the neck x-ray on the second visit.

3. Respondent failed to obtain an Ear, Nose and Throat consultation on the second visit after Respondent failed to note the abnormality on the x-ray and/or because of the severity of Patient F's symptoms.

4. Respondent's actions created a risk that Patient F would dehydrate and die or suffer from a respiratory arrest due to upper airway obstruction.

G. Respondent provided medical care to Patient G, a 31-year-old male, on December 4, 2005, at 7:00 AM, after arriving by ambulance at 6:00 AM at Mercy Hospital's Emergency Department, with complaints of chest pain which started at 1:00 AM. An EKG performed at 6:11 AM revealed changes suggestive of an acute myocardial infarct. Repeated EKG done at 7:24 AM showed a typical inferior wall myocardial infarction. Patient G was sent to the Cath lab, where a PTCA was done.. Respondent's care and treatment of Patient G failed to meed accepted standards of medical care in that:

1. Respondent failed to accurately appreciate the seriousness of the initial

EKG in a timely manner. Respondent's opinion that "tombstone" changes are necessary before the EKG can be called abnormal is grossly under-diagnosing abnormalities on the EKG.

SPECIFICATIONS

FIRST SPECIFICATION

PRACTICING THE PROFESSION WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing The Profession With Negligence On More Than One Occasion, in violation of N.Y. Education Law § 6530(3), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, B and B.1, B and B.2, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, E and E.7, F and F.1, F and F.2, F and F.3, F and F.4, and/or G and G.1.

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with Practicing The Profession With Incompetence On More Than One Occasion, in violation of N.Y. Education Law § 6530(5), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, B and B.1, B and B.2, C and

C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, and/or G and G.1.

THIRD SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS NEGLIGENCE ON A PARTICULAR OCCASION

Respondent is charged with Practicing The Profession With Gross Negligence On A Particular Occasion, in violation of N.Y. Education Law § 6530(4), in that Petitioner charges the following:

1. A and A.1, A and A.3, B and B.1, B and B.2, C and C.2, D and D.4, D and D.5, D and D.6, D and D.7, E and E.3, E and E.3, E and E.5, F and F.2, and/or G and G.1.

FOURTH SPECIFICATION

PRACTICING THE PROFESSION WITH GROSS INCOMPETENCE

Respondent is charged with Practicing The Profession With Gross Incompetence, in violation of N.Y. Education Law § 6530(6), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.1, A and A.3, B and B.1, B and B.2, C and C.1, C and C.2, C and C.3, C and C.4, C and C.5, D and D.1, D and D.2, D and D.4, D and D.5, D and D.6, D and D.7, E and E.1, E and E.2, E and E.3, E and E.4, E and E.5, E and E.6, F and F.1, F and F.2, F and F.3, F and F.4, and/or G and G.1.

FIFTH SPECIFICATION

FAILING TO MAINTAIN A RECORD FOR EACH PATIENT WHICH ACCURATELY REFLECTS THE EVALUATION OR TREATMENT OF THE PATIENT

Respondent is charged with Failing To Maintain A Record For Each Patient Which Accurately Reflects The Evaluation Or Treatment Of The Patient, in violation of N.Y. Education Law § 6530(32), in that Petitioner charges the following:

1. The facts in Paragraphs A and A.2, A and A.4, A and A.5, C and C.1, D and D.1, D and D.3, E and E.1, and/or E and E.7.

DATED: March 17, 2010
Albany, New York

REDACTED

PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct