STATE OF NEW YORK
DEPARTMENT OF HEALTH
433 River Street, Suite 303 Troy, New York 12180-2299

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

Public

July 8, 2010

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Tomasz Wojciech Kowacz, M.D.
REDACTED

George Rosenbaum, Esq.
ROSENBAUM & ROSENBAUM, PC
110 Wall Street
New York, New York 10005

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

RE: In the Matter of Tomasz Wojciech Kowacz, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 10-122) 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

COPY

IN THE MATTER

OF

TOMASZ WOJCIECH KOWACZ M.D.

DETERMINATION

AND

ORDER

BPMC #10-122

A Notice of Hearing, and Statement of Charges both dated September 7, 2009 were served upon the Respondent **TOMASZ WOJCIECH KOWACZ M.D.** Chairperson **GERALD M. BRODY M.D., JAMES DICKSON M.D.,** and **RANDOLPH MANNING Ph.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 **TERRENCE SHEEHAN ESQ. & CHRISTINE RADMAN ESQ.,**[1] of Counsel. The Respondent TOMASZ WOJCIECH KOWACZ M.D. appeared in person and by Counsel **GEORGE ROSENBAUM 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.

[1] On January 13, 2010, Ms. Radman took over the case from Mr. Sheehan who was leaving the Department (Tr. 687).

PROCEDURAL HISTORY

Notice of Hearing & Statement of Charges	September 7, 2009[2]
Pre hearing Conferences	September 24, 200 & October 14, 2009
Respondent's Answer	October 1, 2009
Hearing Dates	November 24, 2009; December 3, 2009; December 10, 2009; January 13, 2010; January 22, 2010 and March12, 2010
Witnesses for Petitioner	Brett Blatter M.D., Joseph Greenidge Nurse, Richa Pathak M.D.
Witnesses for Respondent	Marta Zahaykevich Ph.D., Jeffrey L. Hamblin M.D., Narasimhan L. Narasimhan M.D., Tin Oo M.D., Tomasz Wojciech Kowacz M.D., Joseph A. Charlot M.D.
Parties Briefs	April 19, 2010
Deliberations Date	May 7, 2010

STATEMENT OF THE CASE

The State Board of Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York pursuant to Section 230 et seq. of the Public Health Law of New York. This case was brought by the New York State Department of Health, Office of Professional Medical Conduct (hereinafter "Petitioner" or "Department") pursuant to Section 230 of the Public Health Law. TOMASZ WOJCIECH KOWACZ M.D. (hereinafter "Respondent") is charged with six specifications of misconduct regarding two patients. The Respondent is charged with: gross negligence, negligence on more than one occasion, patient abandonment, moral unfitness, and failing to maintain patient records as set forth in Section 6530 of the Education Law

[2] During the hearing on January 22, 2010 in the midst of Respondent's direct case, the Department withdrew the second line of Charge B.2 which is reflected on Department's Exhibit 1. The Department also sought to amend Charge B.2, and upon objection by Respondent the amendment was denied, as the proposed amendment would have unfairly prejudiced Respondent.

of the State of New York ("Education Law"). The Respondent denies the First through the Sixth Specifications set forth in the Statement of Charges. The Respondent denies each and every factual allegation except admits that he treated Patient A and Patient B, on June 18 & 19, 2008, at the Psychiatric Emergency Department at Kings County Hospital Center, Brooklyn, New York (" emergency department or E.D."), and "approximately nineteen (19) hours after Respondent had evaluated Patient A, the Patient was still waiting in the emergency department to be admitted to the in-patient unit" (Ex. A). The Respondent requests that all factual allegations regarding Patients A and Patient B, and the six specifications of misconduct set forth in the Notice of Hearing and Statement of Charges, attached hereto and made part of this Decision and Order, and marked as Appendix A, be dismissed in their entirety.

FINDING OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Unless otherwise noted, all findings and conclusions set forth below are the unanimous determinations of the Hearing Committee ("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 finding of fact:

1. On or about 1999, Tomasz Wojciech Kowacz M.D., the Respondent, was authorized to practice medicine in New York State by the issuance of license number 214508 (Ex. 1).

2. Kings County Hospital Center, Brooklyn, New York has a comprehensive psychiatric emergency program ("CPEP"), which includes a psychiatric emergency unit for patient observation prior to admission to the hospital or discharge (Tr. 34-35).

3. The Respondent treated Patient A & Patient B on June 18, 2008 & June 19, 2008, at Kings County Hospital Center, Brooklyn, New York (Ex. A, 2,3, 4&5). At the time, both Patient A & Patient B were women of childbearing age and because certain medications could cause birth defects, pregnancy tests were ordered before these medications were to be given these patients (Ex 2,3, 4&5, 13; Tr. 150-53, 1205,1222, 1287,1357).

4. The attending psychiatrist in the emergency department is primarily responsible for the care and treatment of the patients including patient evaluation, and issuance of medical orders for tests and medications (Tr. 55-56, 202-205, 512,1225).

5. The emergency department has three levels of observation and in June 2008 all E.D. patients were to be observed at least hourly by the nursing staff (Tr. 964-67, 1242-44).

6. In June 2008 and well before that time, patients in the Kings County Hospital Center E.D. were frequently found lying on the floor, and it was not unusual for patients to wait two or three days before being admitted to the hospital and given a bed (Tr. 560-61, 706-708,717-21, 810-17, 828, 884, 920-22, 1062-1063, 1138-41; Ex.9A).

DISCUSSION & CONCLUSIONS

The Hearing Committee's conclusions were unanimous and based on the entirety of the witness testimony and 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 Hearing Committee did not sustain the Factual Allegations in Paragraph A, A.1, A. 2 and A. 3, and the First, Second, Third, Fourth and Fifth Specifications set forth in the

Statement of Charges that specifically relate to gross negligence; negligence on more than one occasion; moral unfitness, patient abandonment; and failure to maintain a medical record that accurately reflects the care and treatment of Patient A (Ex.1, Education Law Sections 6530 (3), 6530(4), 6530(20) & 6530 (30) &6530(32); *See* ALJ Ex. 1A "Definitions of Professional Misconduct-Greenberg Memorandum"). The Hearing Committee sustained the factual allegations in Paragraph B, B.1, B.2, and B.3, and the Sixth Specification set forth in the Statement of Charges that specifically relates to failure to maintain a medical record that accurately reflects the care and treatment of Patient B (Ex. 1, Education Law Section 6530(32)).

Patient A

The Department's expert witness Dr. Blatter is a psychiatrist and Director of Psychiatric Emergency Services Columbia University, New York Presbyterian Hospital (Ex. 7). In his role as Director of Psychiatric Emergency Services for a CPEP he has supervised attending and resident physicians, and directed patient care. Dr. Blatter provided seminal testimony about acceptable standards of medical care in a psychiatric emergency room and acknowledged that each hospital's culture, systems, and protocols impact on an individual physician's practice.

The Department first charged the Respondent with failing to provide appropriate and timely psychopharmacologic treatment to Patient A. The Respondent was the attending psychiatrist in the E.D. when he saw the patient just before noontime on June 18, 2008 (Ex. 2). The record reflects that the patient had been given Ativan (Ex. 2 p. 42). Respondent evaluated the patient and because Patient A was of childbearing years a pregnancy test was ordered before anti psychotic medications were to be administered to the patient, and Respondent anticipated that the test results would be forthcoming. When Respondent's shift as attending ended on or about 5:00pm on June 18, 2008, he transferred the patient to the attending physician on duty.

Dr. Blatter confirmed that the attending psychiatrist is the person responsible for the evaluation, care and treatment of the patients in the E.D, and that it was reasonable for Respondent as attending to order tests and to wait on the test results before administering medications.

The Department also charged the Respondent with failing to indicate an observation level for Patient A and that the patient's condition required a "high level of observation." Dr. Blatter testified that Respondent was responsible for ordering observation of Patient A, however, he did not say the patient required a heightened level of observation. There is no check mark in the record indicating the level of observation Patient A was to receive in the E.D., however, absent a designated level of observation E.D. nursing staff were to observe the patient on an hourly / "routine" basis. Respondent testified that a heightened level of observation is required if a patient is violent, suicidal or homicidal, and in his clinical judgment at the time he evaluated Patient A, she did not require a heightened level of observation (Tr. 964-67).

The final charge by the Department regarding Patient A is as follows:

"Approximately 19 hours after Respondent had evaluated Patient A, the Patient was still waiting in the emergency department to be admitted to the in-patient unit. At that time, the Respondent entered the emergency department waiting area and looked directly at Patient A failed to check on Patient A, who was lying face down on the floor in an unnatural posture. Rather than immediately attending to A and evaluating her medical condition, Respondent abruptly left the waiting room, failing to summon help and failing to provide or arrange for appropriate evaluation or treatment for the Patient. The Respondent abandoned Patient A."

When the Respondent's counsel asked Dr. Blatter whether it was acceptable for a psychiatrist working in a CPEP emergency department not to evaluate a patient who was lying on the floor Dr. Blatter confirmed his opinion that:

"If patients commonly sleep on the floor in the psychiatric emergency department and are not usually asked to get up and move to a bed, then Dr. Kowacz's behavior would be acceptable and in line with the prevailing culture in that area of the hospital" (Tr. 257).

Dr. Blatter testified that he never worked at Kings County Hospital Center E.D. and did not have any direct knowledge of whether patients would frequently lay down on the floor.

The Respondent and emergency department staff witnesses provided vivid descriptions of the deplorable conditions and "culture" at Kings County Hospital in June 2008 including overcrowding and lack of beds. Patients were frequently lying on the floor and often waited two and three days before being admitted into the hospital where only then would they be given a bed. The patients who were given a bed in the E.D. often left the bed because it was housed in a small room with six beds jammed into it. Patients with no bed assignment were left to sleep in stationary plastic seats in the waiting area or on the floor. Eventually, after being given medications with sedative effects and/or waiting hours and sometimes days to be admitted into the hospital, patients would lie down on the floor. Emergency department staff testified that waking patients up to get them off the floor was pointless given that they were resting and in most cases no bed was available for them.

The Hearing Committee viewed a surveillance video (without audio) which showed Patient A calmly walking into the E.D. waiting area at approximately 5:30a.m.,on June 19, 2008 and sitting down on a stationary seat located in a far corner of the room away from other patients (Ex. 9A). A short time after sitting down, Patient A is seen slipping to the floor (Tr. 244-45). For more than one hour Patient A is seen on the floor and other E.D. patients are mulling about the area, and at one point a patient is seen lying down across a few stationary seats near where Patient A is lying on the floor. Periodically, security staff is seen passing by the waiting area and they appear to acknowledge that the patient is lying on the floor; however, they do not approach the patient.

After Patient A is seen lying on the floor for more than one hour, Respondent who had not been the patient's attending psychiatrist for some twelve hours is seen at the opening to the waiting area, his back is to the camera. Respondent appears to visually scan the waiting area and for a split second he looks toward where the patient is lying on the ground. The surveillance video confirms Respondent was moving quickly, and he entered and exited the area in approximately two seconds time. Respondent testified that when he went to the waiting area he was looking for a male patient he was assigned to evaluate and was calling his name, and it did not "register" that Patient A was on the floor (Tr. 912-914, 1058-1064).

Based on the foregoing, the Hearing Committee determined that they could not sustain any of the factual allegations or charges as they relate to Patient A. The record reflects the patient was given Ativan, and as the attending psychiatrist waiting on the results of the pregnancy test before giving the patient other medications was reasonable. Patient A was to be observed by nursing staff on an hourly basis, and the Department failed to show that the she required a "high level of observation." Finally, under the prevailing culture and conditions existing in the emergency department in June 2008, the Committee found Respondent could not be held responsible for discerning why Patient A was lying on the floor or hastening her admission into the hospital after nineteen hours in the E.D.

Patient B

The Department charged the Respondent with failing to perform and record an accurate psychiatric assessment, taking an inadequate history of present illness and symptoms, inaccurately listing interpersonal relationships and social supports, recording a mental status exam that is "incorrect and totally inconsistent with all other exams done," and falsely stating voluntary admission status for Patient B (Ex.1). The Department also charged Respondent with

failing to diagnose and provide appropriate psychopharmacologic treatment to a patient who was in a "psychotic, delusional state." The record reflects that Patient B was brought to Kings County Hospital Center by ambulance from a shelter because she was acting abnormally and had not been taking her medications for a previously diagnosed psychiatric condition (Ex. 5). Respondent notes in the record that the patient has "strong social supports," and was voluntarily admitted into the E.D. The record also reflects that patient states " I'm fine" and "I'm not staying," and Respondent did not immediately medicate the patient and he ordered close observation of the patient.

Dr. Blatter testified that Respondent's record of the patient evaluation including his examination and diagnosis is both inconsistent and inaccurate. Dr. Blatter testified that on its face Patient B's record shows no evidence of social support as no family or friends are identified and she arrived at the hospital by ambulance from a shelter. The record gives no indication of the patient's desire to be admitted into the E.D., in fact it is noted that she said "I'm not staying." Dr. Blatter believes that at the time Respondent evaluated and admitted Patient B to the emergency department she was very ill and even if it is presumed that she signed a consent form she lacked the capacity to consent to her admission (Tr. 309-321). Patient B was unmedicated, and Dr. Blatter believes that it would be very unusual for an unmedicated patient to experience such a dramatic change in such a short period of time, and for this reason the nursing note indicating the patient was observed to be angry and loud and professing she is a four year old "baby goddess reincarnated" only served to bolster his belief that the patient was in a psychotic /delusional state upon admission to the E.D. (Tr. 321, 335-336, 377).

Respondent said that at the time of his evaluation the patient was relatively "normal,"

and argued that the patient's condition deteriorated post-admission noting that a few hours had passed when the patient was observed to be exhibiting bizarre behavior (Tr. 1330-33,1361-62). When Respondent was questioned about why he ordered close observation of the patient, he denied giving the order (Tr. 1395-1400). Respondent could not explain why he did not medicate Patient B and /or how she had the capacity to voluntary admit herself given her presenting condition and history, which strongly suggests she was very ill and lacked the capacity to voluntarily consent to her admission into the E.D.

The Hearing Committee found Dr. Blatter's testimony about the inaccuracies and inconsistencies in the patient record to be highly credible. While the Committee believes that Respondent genuinely tried to understand and explain the record he created for Patient B, he himself could not make sense of it. Based on the foregoing, the Hearing Committee concluded that Respondent's failure to accurately record information, analyze and diagnose Patient B falls below acceptable standards of medical practice and constitutes a failure to maintain a medical record that accurately reflects the care and treatment of a patient (Ex. 1, Education Law 6532).

DETERMINATION AS TO PENALTY

The Hearing Committee found the Respondent to be a dedicated physician who has a genuine interest in his patients and is respected by his colleagues. However, it cannot be ignored that his treatment of Patient B falls well below acceptable standards of medical practice. The Hearing Committee believes that Respondent's long-term exposure to the desperate conditions in the Kings County Hospital Center E.D. has blurred his understanding of what constitutes good medical practice.

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

his practice with oversight and refresher training of his clinical, diagnostic, prescribing, and record keeping practices. Respondent shall be on probation for three years and during the first year of probation he shall work in an Article 28 facility with a practice monitor. 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 Paragraph A, A.1, A.2, and A.3, and the First, Second, Third, Fourth and Fifth Specifications of misconduct as set forth in the Statement of Charges (Ex. 1) are **DISMISSED;**

2. The Factual Allegations in Paragraph B, B.1, B.2, and B.3, and the Sixth Specification of misconduct set forth in the Statement of Charges (Ex. 1) are **SUSTAINED;**

3. The Respondent shall be on probation for a period of three years and during the first year of probation shall work in an Article 28 facility with a practice monitor (Appendix B).

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

Tuckahoe, New York
DATED: July 8, 2010

REDACTED

BY: _____

GERALD M. BRODY M.D., Chairperson
JAMES DICKSON M.D.
RANDOLPH MANNING Ph.D.

To: Tomasz Wojciech Kowacz M.D.
REDACTED

George Rosenbaum, Esq.
ROSENBAUM & ROSENBAUM, PC
110 Wall Street
New York, NY 10005

Christine Radman, Esq.
NYSDOH -Bureau of Professional Medical Conduct
90 Church Street
New York, NY 10007

Appendix A

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

IN THE MATTER

OF

TOMASZ WOJCIECH KOWACZ, M.D.

NOTICE
OF
HEARING

TO: Tomasz Wojciech Kowacz, M.D.

REDACTED

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law §230 and N.Y. State Admin. Proc. Act §§301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on OCTOBER 15, 2009, at 10:00 a.m., at the Offices of the New York State Department of Health, 90 Church Street, 4th Floor, New York, New York 10007, and at such other adjourned dates, times and places as the committee may direct.

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

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

Department attorney: Initial here_____

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the New York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 433 River Street, Fifth Floor South, Troy, NY 12180, ATTENTION: HON. SEAN D. O'BRIEN, DIRECTOR, BUREAU OF ADJUDICATION, (henceforth "Bureau of Adjudication"), (Telephone: (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

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

photocopied.

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

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

DATED: New York, New York
September 7 ,2009

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

Inquiries should be directed to: Terrence J. Sheehan
Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street - 4th Floor
New York, New York 10007
212-417-4450

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

IN THE MATTER

OF

TOMASZ WOJCIECH KOWACZ, M.D.

STATEMENT
OF
CHARGES

TOMASZ WOJCIECH KOWACZ, M.D., the Respondent, was authorized to practice medicine in New York State in or about 1999, by the issuance of license number 214508 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated or failed to treat Patient A (Patient names are contained in the attached Appendix) on June 18 and 19, 2008 at the Psychiatric Emergency Department at Kings County Hospital Center, Brooklyn, New York. Respondent's care and treatment of Patient A departed from accepted standards of medical practice in the following respects:

1. The Respondent failed to provide appropriate psychopharmacologic treatment in a timely fashion for an actively psychotic patient who had been determined by the Respondent to be a danger to herself and others. The Respondent inappropriately left Patient A totally unmedicated for a period of approximately 19 hours .

2. Evaluating psychiatrists, such as the Respondent, are required to enter an individualized order for an observation level, i.e., an order to the nursing staff stating the frequency with which Patients are to be observed by the nursing staff. The Respondent inappropriately failed to enter such an order in Patient A's chart. As a result, Patient A did not receive the high level of observation that her condition warranted.

3. Approximately 19 hours after the Respondent had evaluated Patient A, the Patient was still waiting in the emergency department to be admitted to the in-patient unit. At that time, the Respondent entered the emergency department waiting area and looked directly at Patient A, who was lying face down on the floor in an unnatural posture. Rather than immediately attending to Patient A and evaluating her medical condition, Respondent abruptly left the waiting room, failing to summon help and failing to provide or arrange for appropriate evaluation and treatment for the Patient. The Respondent abandoned Patient A.

B. Respondent treated or failed to treat Patient B on June 18 and 19, 2008 at the Psychiatric Emergency Department at Kings County Hospital Center. Respondent's care and treatment of Patient B departed from accepted standards of medical practice in the following respects:

1. Respondent failed to perform and record an accurate psychiatric assessment of Patient B. His history of present illness and symptoms is inadequate. He lists interpersonal relationships and social supports as a "strength" for Patient B, which is inaccurate. The record of his mental status exam is incorrect and totally inconsistent with all other exams done by other mental health professionals before and after the Respondent's exam. The Respondent stated in the chart that the Patient admitted herself voluntarily to the psychiatric ward, which statement is false.

2. The Respondent failed to provide appropriate psychopharmacologic treatment in a timely fashion for this actively psychotic Patient whom the Respondent left totally unmedicated for a period of approximately nineteen hours . ~~Although the Respondent ordered Seroquel, 100 mg. twice daily, he made the order contingent on a negative pregnancy test, which test he failed to order.~~ withdrawn 1/22/10

3. The Respondent failed to diagnose that Patient B was in a psychotic, delusional state.

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 paragraphs:

1. A and A.3

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 paragraphs:

2. A and A.1 - A.3; B and B.1 - B.3.

THIRD SPECIFICATION
PATIENT ABANDONMENT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(30) by abandoning and neglecting a patient in need of immediate professional care, without making reasonable arrangements for their

care, as alleged in the facts of the following paragraphs:

3. A and A.3.

FOURTH SPECIFICATION

MORAL UNFITNESS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(20) by engaging in conduct in the practice of the profession of medicine that evidences moral unfitness to practice as alleged in the facts of the following paragraphs:

4. A and A.3.

FIFTH AND SIXTH 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 the following paragraphs:

5. A and A.2

6. B and B.1 - B.3

DATE: ~~August~~ Sept 7, 2009
New York, New York

REDACTED

Roy Nemerson
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX B
Terms of Probation

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

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

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

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

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

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

8. Within thirty (30) days of the effective date of the period of probation and for the first year of the period of probation (this period shall toll when and if the Respondent is not practicing) Respondent shall practice medicine only in an Article 28 facility when monitored by a licensed physician specializing in psychiatry ("practice monitor") proposed by Respondent and subject to the written approval of the Director of OPMC.

   a. Respondent shall make available to the practice monitor any and all records or access to the practice requested by the monitor, including on-site clinical observation.

   b. The practice monitor shall on a random unannounced basis at least monthly examine a selection (no less than one dozen) of records maintained by Respondent including patient: evaluation, prescribing, testing and diagnostic information. The review will determine whether the Respondent's medical practice is conducted in accordance with the generally accepted standards of professional medical care. Any perceived deviation of accepted standards of medical care or refusal to cooperate with the monitor shall be reported within 24 hours to OPMC.

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

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

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.

10. 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.