NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

November 1, 2021

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Daniel Guenzburger, Associate Counsel
NYS Department of Health
Bureau of Professional Medical Conduct
90 Church Street - 4th Floor
New York, New York 10007

Jordan S. Fensterman, Esq.
Abrams, Fensterman, Fensterman, Eisman, Formato,
Ferrara, Wolf & Carone LLP
3 Dakota Drive
Suite 300
Lake Success, New York 11042

RE: In the Matter of Dmitry Anatolevich Shelchkov, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 21-223) 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
Office of Professional Medical Conduct
Riverview Center
150 Broadway - Suite 355
Albany, New York 12204

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. 2015) and §230-c subdivisions 1 through 5, (McKinney Supp. 2015), "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:

Jean T. Carney, 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 Ms. Carney 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: nm
Enclosure

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

COPY

IN THE MATTER	**DETERMINATION**
OF	**AND**
DMITRY ANATOLEVICH SHELCHKOV, M.D.	**ORDER**
	BPMC-21-223

A Commissioner's Order and Notice of Hearing dated March 2, 2021 and a Statement of Charges dated February 25, 2021 were duly served pursuant to §230(10)(d)(i) of the Public Health Law (PHL) upon Dmitry Anatolevich Shelchkov, M.D. (Respondent). (Exhibit 1; Appendix I.) Elisa E. Burns, M.D., Chair, Ramanathan Raju, M.D., and David F. Irvine, DHSc, P.A., duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee. PHL §230(12)(a). Dawn MacKillop-Soller served as the Administrative Law Judge. The Department of Health, Bureau of Professional Medical Conduct (Department), appeared by Daniel Guenzburger, Esq. The Respondent appeared and was represented by Jordan S. Fensterman, Esq. A transcript of the proceeding was made. (Transcript, p. 1-878.)

The Hearing Committee voted 3-0 to sustain five specifications of misconduct as defined under Education Law §6530: gross negligence §6530(4); gross incompetence §6530(6); negligence on more than one occasion §6530(3); incompetence on more than one occasion §6530(5); and failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient §6530(32). The Hearing Committee voted 3-0 to not sustain two specifications of misconduct as defined under Education Law §6530(2), practicing the profession of medicine fraudulently, and one specification of misconduct as defined under Education Law §6530(21), willfully making or filing a false report, or

failing to file a report required by law. The Hearing Committee unanimously determined to impose the penalty of revocation of the Respondent's medical license pursuant to PHL §230-a(4).

Hearing Record

Pre-Hearing Conference:	March 10, 2021
Hearing Dates:	March 12, 19, 23, April 9, and June 1, 2021.
Witnesses for Petitioner:	David Ian Shapiro, M.D. (Transcript, p. 34-250.) Katelyn Seide, R.N. (Transcript, p. 318-368.) George Neuman, M.D. (Transcript, p. 370-413.)
Petitioner's Exhibits:	1-9
Witnesses for Respondent:	Dmitry Anatolevich Shelchkov, M.D. (Transcript, p. 634-866.) Evgeniy Shelchkov, M.D. (Transcript, p. 260-272.) Natalya Shelchkov (Transcript, p. 273-287.) Ian Gunsolus, Ph.D. (Transcript, p. 420-459.) Mark Gifeisman, M.D. (Transcript, p. 460-626.)
Respondent's Exhibits:	A-D, G, I, L, N, O
ALJ Exhibits:	I and II
Written Submissions received:	June 26, 2021 (Petitioner) and July 9, 2021 (Respondent)
Deliberations held:	August 25, 2021

Findings of Fact

The Hearing Committee unanimously makes the following findings of fact:

1. Respondent Dmitry Anatolevich Shelchkov, M.D. was authorized to practice medicine in New York State on July 9, 2009, by the issuance of license number 253970. (Exhibit 2.)

2. By Commissioner's Order dated March 2, 2021, following an investigation by the Office of Professional Medical Conduct and a recommendation by a Committee on Professional Conduct pursuant to PHL §230(12)(a)(ii), the Respondent was prohibited from practicing medicine due to his activity or practice constituting an imminent danger to the health of the people. The Respondent contested this summary order. (Exhibit 1.)

3. By Recommendation pursuant to PHL §230(12)(a) dated March 29, 2021, following a hearing, the Commissioner adopted the Hearing Committee's recommendation that the summary order suspending his medical license remain in full force and effect until a final decision has been rendered. PHL §230(12)(a). (Exhibit ALJ I.)

4. The subject of this proceeding is the Respondent's anesthesia care and medical recordkeeping involving Patients A, B, C, and D at Woodhull Hospital in Brooklyn, NY between April 21, 2020 and July 3, 2020. These patients experienced harmful complications, including death for Patient A, pulmonary cardiac arrest for Patient B, potential intra-operative awareness for Patient C, and cardio-respiratory arrest for Patient D. (Exhibits 3, 5-7.)

5. During this period, Woodhull Hospital used Epic, an electronic medical record keeping program, to auto-fill vital signs and other important information from anesthesia monitors and transfer it to a patient's medical record. When the Epic automatic transfer function fails, anesthesiologists are required to manually enter important anesthesia details, such as vital signs, complications, and discussions with patients. Anesthesiologists can also record progress notes and addendums into Epic at any time. (Transcript, p. 55-56, 64, 149-150, 171-172, 198-199.)

6. In April and through July of 2020, the post-anesthesia care unit (PACU) at Woodhull Hospital was used to provide care to COVID-19 patients and the operating room was also used as a recovery room following surgeries. (Transcript, p. 675, 681, 692.)

Patient A

7. Patient A was 26 years old, with a gestational period of 40 weeks and five days when she came under the Respondent's anesthesia care at Woodhull Medical Center on July 3, 2020 for placement of an epidural catheter for spinal epidural analgesia during labor and delivery. The Respondent documented administering a test dose of 3cc's of 1.5% lidocaine or 25mg with epinephrine at 21:37 and

100mcg of fentanyl as an epidural bolus at 21:38. He also noted placing 100mcg of fentanyl in an epidural bag for later epidural infusion use. The patient immediately became anxious and experienced labored breathing, stating: "I can't breathe, I feel funny." At 21:39, the patient became pulseless and unresponsive. At 21:40, after a "code blue" was called, the Respondent intubated the patient. At 21:47, emergency physician Matthew Robinson, M.D. responded to the code blue. The patient was extubated and then successfully reintubated at 22:09. The patient experienced multiple cardiac arrests and died at 23:51. (Exhibits 3, 4; Transcript, p. 41, 56-59, 321-329.)

8. The autopsy report confirms the Respondent placed the epidural catheter 34cm deep into the subarachnoid or intrathecal space. The anterior posterior chest x-ray by the medical examiner confirms the findings stated in the autopsy report. The autopsy report also confirms acute-hypoxic ischemic changes to the brain. The toxicology report shows positive findings for bupivacaine, a long-acting anesthetic, at .85 mcg/mL from heart blood. (Exhibits 4, 4-A; Transcript, p. 69, 71-73, 87.)

9. The patient experienced a total spinal from injection of the test dose and bupivacaine into her cerebral spinal fluid. A total spinal occurs when anesthetic drugs are administered in the intrathecal or subarachnoid space and reach the central nervous system, suppressing respiratory sensors. Labor and delivery patients should never unknowingly be given total spinals. Anesthesiologists are required to recognize when this occurs and adjust drug dosages accordingly to avoid harming the patient. (Transcript, p. 51-52, 145.)

10. The Respondent documented in Epic that he inserted the epidural catheter 10cm from the skin when in fact it was 34cm as shown by the autopsy report. (Exhibit 3; Transcript, p. 64.)

11. The toxicology report is inconsistent with the Respondent's documentation in the medical record that fentanyl was administered to the patient. The Respondent's medical record fails to document that he administered the patient bupivacaine. (Exhibits 3, 4; Transcript, p. 76, 423-424.)

12. The Respondent's documentation of the medical record that the catheter was 10cm from the skin, and his failure to record administering the patient bupivacaine were deviations from the standard of care. Anesthesiologists are required to document medical records with accurate and complete information that reflects the care provided. (Transcript, p. 67, 77.)

13. An epidural is a form of neuraxial anesthesia used to control labor pain. In providing epidural anesthesia to patients, anesthesiologists are required to properly place epidural catheters by carefully and slowly inserting a 17 or 18 gauge Tuohy needle, which has a flange to direct the catheter with a stent upwards, through the skin and subcutaneous tissues into the L3-4 or L4-5 interspace to a depth of 10cm. (Transcript, p. 42, 45, 48.)

14. After the catheter is inserted through the skin at a standard depth of 10cm, anesthesiologists are required to wait three to five minutes after administering the test dose of 3ccs of 1.5% of lidocaine with 15mcg of epinephrine before administering any additional anesthetic drugs. The purpose of this requirement is to ensure proper placement of the epidural catheter in the epidural space by assessing the patient's signs and confirming that they include a slight ease of contraction pain but not leg numbness, body warmth, the inability to move, or a drop in blood pressure, all of which signal a spinal block and intrathecal or subarachnoid catheter placement. The Respondent failed to properly insert the catheter and wait the requisite period before administering bupivacaine. (Transcript, p. 49-53, 52-53.)

15. In the event of a total spinal of a labor and delivery patient, anesthesiologists are required to immediately perform intubation. The purpose in this requirement is to provide necessary oxygen to the patient. Intubation involves proper placement of the endotracheal tube by inserting the tube through the vocal cords, hooking the patient up to a CO2 monitor, obtaining equal bilateral breath sounds, and

confirming rapid increases of oxygen saturations. The Respondent did not complete these steps to ensure oxygen supplementation, which was a deviation from the standard of care. (Transcript, p. 77-79, 326.)

16. Immediately after receiving the drugs at 21:37, the patient reported she could not breathe. At 21:40, the Respondent placed the endotracheal tube in the esophagus instead of the trachea, thereby ventilating the stomach and not the lungs. The patient's ETCO2 after the intubation was 5-10 and her oxygen saturations were in the 70's. (Exhibit 3; Transcript, p. 83-84, 321, 329.)

17. While the patient was extubated and successfully reintubated at 22:09, she was deprived of essential oxygen for about 30 minutes while experiencing cardiac arrest, which resulted in hypoxic organ damage, as reflected on the autopsy report. (Exhibit 4; Transcript, p. 84-85, 87-88, 328-329.)

Patient B

18. Patient B, age 62, came under the Respondent's anesthesia care on May 24, 2020 for the administration of general endotracheal anesthesia for an open reduction internal fixation surgery to repair a fractured right tibia. The patient's medical history included sleep apnea, diabetes, chronic obstructive pulmonary disease, hypertension, hypothyroidism, gastroesophageal reflux disease (GERD), depression, anxiety, and obesity. She was a heavy cigarette smoker. The Respondent began general anesthesia at 9:42am. The surgery ended at 14:10, but the patient remained intubated after she was moved from the operating room at 15:44 to the PACU, where she was extubated at either 18:10 or 18:38. The patient was discharged from the PACU to the floor, where she arrived at 18:54 and experienced pulmonary cardiac arrest. (Exhibit 5; Transcript, p. 149, 152-154, 157-164, 181, 557.)

19. The patient's medical history included comorbidities that placed her at extremely high risk for complications from general anesthesia, such as prolonged intubation and respiratory depression. Anesthesiologists are required to document a discussion with such high-risk patients as part of the informed consent process of the risks and benefits of general anesthesia versus other anesthetic

techniques, such as regional or neuraxial anesthesia that affects only one leg or below the waist, less narcotics, or non-drug options. The purpose of this rule is to ensure patients make informed decisions regarding their anesthesia care. (Exhibit 5; Transcript, p. 153-157.)

20. The Respondent documented a general informed consent that fails to reflect such a discussion. The Respondent's failure to record such a discussion that includes a plan for mitigating risks of post-procedure pulmonary complications considering this patient's medical history was a deviation from the standard of care. The purpose of this rule is to ensure patients make informed medical decisions regarding their anesthesia care. (Exhibit 5; Transcript, p. 153-157, 170.)

21. Anesthesiologists are required to evaluate patients with comorbidities who received narcotics and were intubated for six to eight hours for at least one hour following extubation to confirm they can maintain spontaneous ventilation respirations. The Respondent remained responsible for this patient while she was in the PACU, yet he improperly discharged her from the PACU to the floor less than one hour after she was extubated without evaluating her medical status, which was a deviation from the standard of care. (Exhibit 5; Transcript, p. 157, 159, 162-164.)

Patient C

22. Patient C was 31 years old with a gestational period of 37 weeks and four days when she came under the Respondent's anesthesia care at Woodhull Medical Center on May 22, 2020, for placement of an epidural catheter for spinal epidural analgesia during labor and delivery. Like Patient A, the Respondent's placement of the epidural catheter resulted in her experiencing a total spinal. At 3:59am, the Respondent intubated the patient for general anesthesia for an emergent cesarean section procedure. The procedure began at 4:07am, the Respondent started data collection for Epic at 4:09am, and the baby was born at 4:10am. During the procedure, the Respondent administered the patient cefazolin, an antibiotic, and oxytocin "to help the uterus contract" but no anesthetic medications. There

were also no vital signs recorded for the first 25 minutes of the procedure. (Exhibit 6; Transcript, p. 188-189, 191-194, 197, 211-212.)

23. Anesthesiologists who intubate patients for general anesthesia are obligated to provide them with necessary anesthetic drugs, such as general anesthesia, and monitor their vital signs during procedures. These steps are critical for patients given total spinals to ensure continuous monitoring of their blood pressures during procedures and to prevent pain and intraoperative awareness, which can cause post-traumatic stress disorder (PTSD). The Respondent deviated from the standard of care by not administering anesthetic drugs after the baby was born at 4:10am or at some point during the procedure and by not recording vital signs for the first 25 minutes of the procedure. (Exhibit 6; Transcript, p. 194-195, 197-198, 201, 217.)

Patient D

24. Patient D was 47 years old when he came under the Respondent's anesthesia care at Woodhull Medical Center on April 21, 2020, for an exploratory laparotomy following a stab wound to the abdomen. The patient's medical history included obesity, high blood pressure, and acute alcohol intoxication. He was also a heavy cigarette smoker. A laboratory test recorded in the medical record at 15:01 revealed a near fatal blood alcohol content of 232. The Respondent's 15:53 anesthesia encounter note, documented prior to the start of anesthesia, indicates he reviewed "Chart/Labs/Studies." The Respondent started anesthesia at 16:02 and documented that at 18:14, he stopped data collection for electronic recording of the patient's vital signs. At 18:36, the patient experienced cardio-respiratory arrest while recovering in the operating room, where he remained until 21:13. (Exhibit 7; Transcript, p. 220-221, 228, 510.)

25. The Respondent deviated from the standard of care by failing to record the patient's vital signs, medications, and other important details between 18:14 and 21:13. Anesthesiologists are

responsible for their patients' post-procedure medical status, which includes continuously monitoring them during the recovery period to confirm they are medically stable. (Exhibit 7; Transcript, p. 222-224, 228.)

Factual Allegations

The Hearing Committee made the following determinations on the factual allegations in the Statement of Charges. All votes were unanimous (3-0):

Sustained: Factual Allegations A.1, A.2, A.3, B.1, B.2, B.3, B.4, C.1, C.2, D.1, D.2., D.3.

Not sustained: Factual Allegations A.4, A.5.

Evaluation of Witnesses' Testimony

The Petitioner presented anesthesiology expert David I. Shapiro, M.D. Dr. Shapiro has over 20 years' experience as a board-certified anesthesiologist. Beginning in 2001, he was full-time staff anesthesiologist at a private ambulatory center in Seneca, New York, and at Erie County Medical Center in Buffalo, New York, where he remained a faculty member until 2020. He currently works part-time as staff anesthesiologist at Niagara Falls Memorial Medical Center and at Sisters of Charity Hospital in Buffalo, New York, where he handles a variety of basic, acute, and complicated anesthesia cases — including some COVID-19 patients. Dr. Shapiro discussed his familiarity with anesthesiologists' medical record keeping obligations in a hospital setting under ordinary circumstances and during the COVID-19 pandemic and made clear that there were no changes in how anesthesiologists documented anesthesia care in the operating room while caring for individual patients. (Exhibit D; Transcript, p. 40-41, 231-233.) Dr. Shapiro provided detailed accounts of the Respondent's harmful anesthesia care and deficient medical recordkeeping, including his misuse of the Epic electronic documentation system. The Hearing Committee found Dr. Shapiro's professional opinions credible and consistent with the evidence.

The Petitioner also presented Patient A's primary nurse, Katelyn Seide, R.N. and Department OPMC medical coordinator George Neuman, M.D. Dr. Neuman discussed his interview of the Respondent during the OPMC investigation and the Respondent's insistence that he never administered Patient A fentanyl or any other anesthetics after the test dose of lidocaine with epinephrine. He explained that these denials were inconsistent with the medical record in which the Respondent documented giving the patient 100mcg of fentanyl following the test dose, and with the autopsy report confirming the patient received bupivacaine. Dr. Neuman relied on his 35 years of experience practicing clinical anesthesiology to explain the cause of death for Patient A from infusing lidocaine and bupivacaine into the subarachnoid or intrathecal space instead of the epidural space. He also explained the significant and dangerous differences in responses between epidural and subarachnoid or intrathecal administration of those drugs. Nurse Seide described her personal observations of Patient A's rapid deterioration following the Respondent's administration of drugs and his delay in properly ventilating her to ensure necessary oxygen supplementation. The Hearing Committee found these witnesses credible and their testimony consistent with the evidence.

The Respondent presented toxicologist Ian Gunsolus, Ph.D. and anesthesiology expert Mark Gifeisman, M.D. Dr. Gunsolus testified about the forensic value of the toxicology report for Patient A based on his background not as doctor but as an assistant professor with a doctorate in toxicology. He is currently employed by the Medical College of Wisconsin as an assistant professor of pathology and performs toxicological analysis for the hospital. The Hearing Committee credited his opinion that the toxicology findings for Patient A indicate that the initial screening by immunoassay testing was presumptive evidence that fentanyl was not detected. (Exhibit 4; Transcript, p. 330, 435-436, 445, 456.)

The Hearing Committee noted Dr. Gifeisman's extensive anesthesiology background includes current attending anesthesiologist at Bridgeport Hospital and assistant professor of anesthesiology at the

Yale New Haven Health System but was not persuaded by his professional opinions based on contradictions in his testimony. For instance, Dr. Gifeisman suggested an amniotic fluid embolism or preeclampsia caused Patient A's death, yet the evidence showed no embolisms found at autopsy in the microscopic examination of the tissue samples of the lungs and blood or signs of preeclampsia, such as abnormally low platelet counts, headache, upper abdominal pain, or visual changes. (Exhibit 4; Transcript, p. 131, 392, 462-463, 598, 608-612.)

Dr. Gifeisman also claimed there was no risk of intraoperative recall or pain for Patient C when she only received the test dose intrathecally during her cesarean section procedure, which was contrary to his admission that "spinals do recede." (Transcript, p. 528.) His testimony that "(i)f the patient is unconscious, then that's the status of a general anesthesia" has no basis in medicine because a patient can be unconscious without general anesthesia and vital signs were not recorded to confirm her medical status. (Exhibit 6; Transcript, p. 530.) He acknowledged that anesthesiologists "always try to monitor for the state of the patient's unconsciousness," yet this apparent lack of monitoring continued for the first 25 minutes of the procedure. (Transcript, p. 529.) The Hearing Committee also did not find credible his claim that the Respondent's starting data collection in Epic at 4:09am shows he attempted to record vital signs because anesthesiologists are required to recognize when Epic fails to transfer such data from anesthesia monitors and record it manually every few minutes. (Transcript, p. 199.)

Dr. Gifeisman's testimony that Patient D was properly monitored while recovering in the operating room from 18:14 to 21:13 was not persuasive given he acknowledged the importance of ongoing monitoring of this patient's vital signs after his arrest at 18:36 and that other than two handwritten vital signs recorded by nurses after that event, no other physiological monitoring was performed. (Transcript, p. 477-478, 510-511.) He also testified regarding Patient B that "if the patient is otherwise stable and for 40 minutes has remained stable, then there is no reason not to discharge," yet he

acknowledged that the medical record is devoid of physical symptoms, such as rate of breathing or respiratory status, to support such stability prior to her discharge from the PACU. (Transcript, p. 558-560.) The Hearing Committee was not persuaded by his suggestion that monitoring of this patient was "probably continuing" because the medical record contains no such documentation. (Transcript, p. 482-483, 486.) The Hearing Committee noted these inconsistences in Dr. Gifeisman's testimony and his long-standing personal relationship with the Respondent and evaluated his testimony accordingly. (Transcript, p. 508.)

The Respondent testified on his own behalf and presented as witnesses his brother Evgeniy Shelchkov, M.D. and his daughter Natalya Shelchkov. While the Hearing Committee noted the testimony of the Respondent's family members describing his "strong work ethic" practicing general surgery for 15 years in Russia and then anesthesiology for the past 20 years in the United States, including throughout the COVID-19 pandemic, it was not persuaded by their opinions regarding his competent and capable care of patients because they were inconsistent with the treatment records and expert testimony that showed otherwise. (Transcript, p. 262-263, 266, 279, 282, 284-285.)

The Respondent's testimony was forthcoming about his hard work during the pandemic intubating dozens of patients per day, which took a toll on him by affecting his "attention" and making him "very stressed" and "very exhausted" to the point that he became "unconscious for three hours" on one occasion. (Transcript, p. 650, 708, 711-712.) He pointed out that he worked 149 hours between April 12 and April 25, 111 hours from April 26 to May 9, and 104 hours from May 10 to May 24, and intubated 20-25 patients per day. (Exhibit L; Respondent's brief, p. 5; Transcript, p. 665-668.) While the Hearing Committee applauds the hard work of medical providers in hospital settings during the COVID-19 pandemic, it finds that working more hours fails to justify mistakes that come at the expense of patient safety. The Hearing Committee believes that if anything, the Respondent's awareness of his

exhaustion should have heightened his consciousness that being so tired made him more susceptible to mistakes. In evaluating the Respondent's testimony, the Hearing Committee considered his refusal to acknowledge such fallibility and blame of nurses and other hospital staff and even the patients themselves for their poor outcomes. (Respondent's brief, p. 10; Transcript, p. 656, 679, 685, 831-832, 855.)

Conclusions of Law

Fraudulent Practice

The Petitioner did not establish by a preponderance of the evidence the following two factual allegations that pertain to Patient A that the Respondent:

> (1) knowingly and falsely, with the intent to deceive, represented that he inserted the epidural catheter to a depth of 10cm, when, in fact he knew that he had inserted the catheter far greater than 10 cm. (Factual allegation A.4); and
>
> (2) concealed with the intent to deceive that he administered additional anesthetic medication following administration of the test dose, or falsely reported to the Office of Professional Medical Conduct (OPMC) at an interview conducted on December 23, 2020 that he did not administer additional anesthetic agents after administering the epidural test dose. (Factual allegation A.5.)

The Petitioner relies on the autopsy and toxicology reports showing the epidural catheter was placed 34cm deep, and that the patient received bupivacaine, to claim the Respondent knowingly and falsely recorded in the medical record inserting the epidural catheter 10cm and fraudulently represented on December 23, 2020 that he administered neither fentanyl nor any other anesthetic medication after the test dose. (Petitioner's brief, p. 7-9.) The Respondent claims the evidence fails to support the Respondent's fraudulent practice or that he filed a false report. (Respondent's brief, p. 20.) The Hearing Committee determined that the evidence supports the conclusion that the Respondent recklessly fed the

catheter through the skin and more than 30cm into the patient without being aware of its depth or what drugs he administered. This documentation was not done intentionally to deceive.

The evidence established that as of the December 23, 2020 interview with OPMC, the Respondent had no awareness of the catheter depth or that he gave the patient bupivacaine. Sadly, his testimony conveyed his seemingly genuine surprise upon learning that the catheter was "30 centimeters in," describing it as "unexpectantly deep" and "unintentional," and that bupivacaine was administered, testifying "when I see autopsy records and bupivacaine is present, maybe I use it. I cannot tell you exactly. I don't remember." (Transcript, p. 833, 847, 851, 857.) The autopsy and toxicology reports identifying bupivacaine and the precise depth of the catheter are dated February 21, 2021, and December 30, 2020, respectively, which was after the December 23, 2020 OPMC interview was completed. OPMC medical coordinator George Neuman, M.D. testified that he had not received these reports by the date of the interview. Because Dr. Neuman did not have the reports and because the medical record contains "no entry" for bupivacaine, he did not ask the Respondent about these two important issues at the interview. (Exhibits 4, 4-A; Transcript, p. 376, 381-382, 392, 847.)

While the Hearing Committee finds the Respondent's unawareness of such critical patient care information unacceptable and irresponsible, especially since he should have known and documented that he administered the patient bupivacaine and should have realized he inserted the catheter beyond 10cm due to her unconsciousness, which Dr. Shapiro testified "always indicates" a total spinal, it concludes that the requisite elements of intent or knowledge are missing to sustain these two factual allegations. (Transcript, p. 146.)

The Hearing Committee voted 3-0 that the Respondent's conduct did not constitute practicing the profession fraudulently under Education Law §6530(2) or willfully making or filing a false report pursuant to Education Law §6530(21). Fraudulent practice requires "proof of either an intentional

misrepresentation or concealment of a known fact." Matter of Patin v. State Bd. For Professional Med. Conduct, 77 A.D.3d 1211, 1214 (3d Dept. 2010).

Inaccurate Medical Recordkeeping

While the Respondent admits he is "guilty of certain minor record keeping lapses," the Hearing Committee finds no valid excuse for his volume of documentation failures regarding these patients. (Respondent's brief, p. 21.) The Hearing Committee noted that for all these patients, the Respondent consistently misused the Epic electronic medical record program by not recording important information into its templates, such as vital signs and medications, or by absentmindedly documenting inaccurate details that provided misleading accounts of the care he provided. The Petitioner correctly relies on Dr. Shapiro's testimony in its brief to point out that when the Epic system fails to automatically transfer data such as vital signs into the medical record, anesthesiologists are required to "manually click them in." (Petitioner's brief, p. 15; Transcript, p. 199.) The Hearing Committee rejected the Respondent's attempt to blame his medical record deficiencies on the "significant" and "tremendous problems with the Epic EMR system." (Respondent's brief, p. 4.) As Dr. Shapiro explained, the program has "an easy function," to quickly and correctly "click" in or manually enter information — even in emergency cases — contemporaneously or after a case is completed. (Transcript, p. 82, 150, 171-172, 198-199, 245-246.) The Hearing Committee agreed with Dr. Shapiro's description of the Epic program as "a record" of the care provided to patients and concludes that the Respondent failed to fulfill his duty to use that record keeping system properly. (Transcript, p. 56.)

There were numerous instances of unacceptable recordkeeping by the Respondent. He recorded in the templates for Patient A "10" for "Catheter Depth at Skin (cm):," "Adequate block" for "Patient Documentation:," and "CSF aspirated" for "catheter passed easily and tolerated procedure well." These entries grossly mischaracterized this patient's serious complications that included a difficult catheter

placement that led to her unconsciousness and a total spinal and catheter insertion beyond 10cm. (Exhibit 3; Transcript, p. 182, 831.) Dr. Shapiro's testimony about how "extremely rare" it is not to note CSF fluid from aspirating an intrathecal catheter reinforced for the Hearing Committee just how careless the Respondent was in his medical record keeping. (Transcript, p. 54-55.) Another example is his failure to document vital signs for Patient C for the first half of her cesarean section procedure even though she had a total spinal that Dr. Shapiro explained required monitoring of her blood pressures "minute to minute." (Exhibit 6; Transcript, p. 197-198, 200-201.)

For Patient B, the Respondent entered "No" for "Anesthetic complications:," which was clearly erroneous since this patient experienced pulmonary cardiac arrest upon her arrival to the floor less than one hour after she was extubated in the PACU. (Exhibit 5; Transcript, p. 160, 174.) He also entered "Anesthesia Risks/Benefits/Altenatives (*sic*) Discussed" for "Pre-op Assessment:" and "yes" for "Anesthesia Consent?," without documenting that he met the requirements of informed consent. There is no documentation to show he discussed with this patient that her comorbidities like sleep apnea placed her at extremely high risk for post-procedure pulmonary complications from general anesthesia, including prolonged intubation and respiratory depression, or considered a plan to mitigate such risks by using neuraxial or regional anesthesia, less narcotics, or no drugs. (Exhibit 5; Transcript, p. 153, 156, 750, 757-758.) He also failed to document instructions for monitoring this patient when transporting her from the PACU to the floor, which the Hearing Committee found particularly troubling since the evidence failed to show he evaluated her prior to the discharge. (Transcript, p. 162-163.)

In the case of Patient D, the Respondent entered "18:14" for "Reversal," "Extubation," "Anesthesia Release," "Stop Data Collection," "Anesthesia Stop," "Emergence," Anesthesia Release," and "Handoff," which shows, according to Dr. Shapiro, that he "clicked all those buttons at once." (Exhibit 7; Transcript, p. 245.) This resulted in the Respondent's failure to record vital signs,

medications, and other critical data from 18:14 to 21:13 even though this patient experienced cardio-respiratory arrest at 18:36 and had a blood alcohol content of 232, which Dr. Shapiro explained lowered his "requirements for anesthetic agents." (Exhibit 7; Transcript, p. 220-221, 224, 228.) The Hearing Committee rejects the Respondent's excuse that he did not know about this blood alcohol content. He should have been aware of it since it was recorded at 15:01 on April 21, about one hour prior to the start of anesthesia at 16:02. (Exhibit 7; Transcript, p. 685, 688-691.) The Hearing Committee disagrees with the Respondent's claim that "vitals and medication are noted at 18:36 and 18:38" and show the patient was monitored because these handwritten readings by nurses fail to demonstrate the Respondent's continuous monitoring of the patient's post-procedure status, as required. (Exhibit 7; Respondent's brief, p. 18; Transcript, p. 224, 236-237, 244, 694-695.)

Incompetence and Negligence

The Respondent failed to exercise the required level of care and demonstrate the requisite knowledge or skill to practice the profession when he failed to record drugs administered, the risks and benefits of certain anesthesia and a plan to address risks, monitoring instructions, vital signs, and critical events, electronically and manually. The Respondent's documentation failures risked harm to these patients because other providers rendering care to them were deprived of important information needed to make treatment decisions.

The Respondent claims that the "adverse events that arose in the administration of epidurals" for Patients A and C "were the result of known complications" that do not "equate to negligence or incompetence." (Respondent's brief, p. 4.) The Hearing Committee disagrees and takes the view of the Petitioner that within "approximately a one-month period," both labor and delivery patients experienced "total spinals" that were "preventable." (Petitioner's brief, p. 5-6.) Dr. Shapiro pointed out the rare occurrence of intrathecal placement, stating that only "about one in one thousand epidural catheters

inadvertently enter the thecal space." (Transcript, p. 54.) While the Petitioner did not charge the Respondent with administering Patient C a second anesthetic drug that he never recorded, the Hearing Committee agreed with Dr. Shapiro that like Patient A, her unconsciousness and total spinal were the result of the Respondent administering her "something else" other than test dose intrathecally that he should have recognized and addressed. (Transcript, p. 192-193.)

Even though Patient C was intubated for general anesthesia due to experiencing a total spinal, the Respondent failed to give her any anesthetic drugs after the baby was born at 4:10am or at any point during the procedure. (Transcript, p. 197, 202.) The Respondent should have given this patient "some general anesthetic" after the baby was born to ensure she remained anesthetized. Dr. Shapiro explained the reason for this is that total spinals wear off in about 15 minutes from the "top down." (Transcript, p. 194, 197, 217.) According to Dr. Shapiro, the Respondent's failure to give additional anesthetic drugs subjected this patient to risks of harm, including intraoperative awareness from becoming conscious and feeling paralyzed, which can cause PTSD. (Transcript, p. 194-195, 198.) The Hearing Committee is not persuaded by the Respondent's claim that "(t)here was never any indication that the patient required additional anesthetic agents" given the apparent lack of monitoring for the first 25 minutes of the procedure. (Respondent's brief, p. 14; Transcript, p. 199-201.)

The Hearing Committee agrees with Dr. Shapiro's description of an epidural placement as "a tactile procedure that takes a lot of training and experience" and finds the Respondent showed a total lack of skill when he improperly placed Patient A's epidural catheter. (Respondent's brief, p. 7; Transcript, p. 102.) The Respondent blamed his improper catheter placement on the "pandemic," the late time of day, the "vapor" on his "goggles" affecting his ability to see properly, and Patient A's "screaming" and "pain," all of which he claims caused him to be "distracted" and unable to "pay attention." (Transcript, p. 831-832, 850, 855-857.) The Hearing Committee rejects these excuses and

agrees with Dr. Shapiro that anesthesiologists are responsible for recognizing such situations and responding accordingly by adjusting their technique and medications, neither of which the Respondent accomplished. (Transcript, p. 145.)

Dr. Shapiro explained that proper placement of an epidural catheter involves: (1) using the black markings on the catheter to measure its depth 10cm from the skin; (2) aspirating the catheter to rule out CSF fluid; and (3) waiting three to five minutes after administering the test dose before giving additional anesthetic drugs to confirm the patient's symptoms include a slight ease of contractions but not leg numbness, chest warmth, and immobility, all of which indicate intrathecal or subarachnoid placement. (Transcript, p. 50, 52, 54-55.) The Respondent completed none of these steps. The Hearing Committee agrees with Dr. Shapiro that the depth of 34cm is "beyond the realm that any catheter should ever be placed in the epidural space" and concludes that the Respondent lost control of the extensive amount of catheter he placed inside this patient and then immediately loaded Bupivacaine. (Transcript, p. 66.) Dr. Neuman explained that compared to epidural administration, which produces "virtually no result," subarachnoid administration of "2cc of 0.75 percent of Bupivacaine" provides a "very profound result." (Transcript, p. 402.) The Respondent claims to have experience performing 10,000 epidural catheters, yet the Hearing Committee noted how he never took any of the corrective measures he alluded to during his testimony to address such a catheter complication — to "withdrawn (*sic*) it back and to see the mark" or to "remove to see where it is actually situated." (Transcript, p. 650, 832-833, 850.)

The Hearing Committee noted that Patient A's complications worsened when the Respondent failed to immediately administer oxygen. Nurse Seide testified that she and the obstetrical attending resorted to directing him to "secure an airway" and "ventilate the patient" because he remained "frozen" with no "immediate reaction" after the patient's collapse. (Transcript, p. 323-324.) The Respondent's insistence that his intubation was done properly is contrary to all the evidence in this case, including (1)

his failure to properly place the endotracheal tube by visualizing the vocal cords, confirming equal bilateral breath sounds, and connecting the patient to a CO2 monitor to check placement of the tube in the trachea and not the esophagus; (2) the patient's very low ETCO2 of 5-10 and oxygen saturation in the 70's; (3) the extubation and successful intubation at 22:09 that returned spontaneous respirations 30 minutes after the Respondent's initial intubation; and (4) the hypoxic organ damage identified on the autopsy report, which Dr. Shapiro explained confirmed the patient's deprivation of oxygen. (Respondent's brief, p. 9; Transcript, p. 79-85, 329, 817, 835, 841). The Hearing Committee rejected the Respondent's excuse that he had no time to check his proper placement of the endotracheal tube, especially since Matthew Robinson, M.D., the emergency physician who responded to the code blue, somehow managed to complete and document this process. (Exhibit 3; 843-844.)

The Respondent claims the "tremendous amount of blood loss" was not from "trauma of the airway" but from an amniotic fluid embolism or due to Dr. Robinson's "multiple failed attempts at intubation during the code." (Respondent's brief, p. 4; Transcript, p. 835-836.) These assumptions are not supported by the evidence. According to Dr. Shapiro, there were "no embolisms" found at the autopsy and "(t)he patient had no hemorrhage other than trauma to the airway." (Transcript, p. 131, 135-136.) Dr. Shapiro even mentioned how common it is for a labor and delivery patient to have an oropharyngeal injury during intubation because they have "increased vascularity of their tongues" and "oropharynges." (Transcript, p. 147.) The Hearing Committee believes such blood loss, the patient's abnormal ETCO2 and oxygen saturation, and the hypoxic organ damage on the autopsy report suggest the Respondent improperly placed the endotracheal tube in the esophagus and not the trachea, which resulted in ventilating the stomach and not the lungs. (Exhibit 3, 4; Transcript, p. 85, 87-88.)

The Petitioner claims Patient B was prematurely discharged from the PACU to the floor because she was extubated at either 18:10 or 18:38 and sustained cardiac arrest at 18:54, which was less than one

hour later. (Petitioner's brief, p. 11.) The Respondent claims the discharge of the patient was timely because it occurred "more than 40 minutes after she had been extubated." (Respondent's brief, p. 12.) The Hearing Committee agrees with Dr. Shapiro that due to this patient's sleep apnea and other comorbidities, which resulted in her prolonged intubation, the standard of care required the Respondent to evaluate her spontaneous respirations for at least one hour following extubation prior to discharging her from the PACU. (Transcript, p. 149, 152-153, 160, 164, 777, 781.) The Hearing Committee rejected the Respondent's claim that Patient B's prolonged intubation was because she was "taking a lot of medication illegally" and agrees with Dr. Shapiro that even if she had been taking such drugs, which the evidence does not support, this patient's sleep apnea made her "more susceptible to postoperative respiratory depression than non-sleep apnea patients on the same medication." (Transcript, p. 175.)

The Hearing Committee voted 3-0 that the Respondent's conduct constituted professional misconduct as defined in Educ. Law §6530(32), failing to maintain records for each patient that "accurately reflect the evaluation and treatment of the patient." Anesthesiologists are required to maintain medical records that completely and accurately detail the care they provide to patients. Mucciolo v. Fernandez, 195 A.D.2d 623, 625. (3d Dept. 1993). The Respondent's documentation for all four patients was filled with omissions and inaccuracies, which risked harm to them because other providers were never properly apprised of their care.

The Hearing Committee voted 3-0 that the Respondent's conduct constituted misconduct under Education Law §6530(5), incompetence on more than one occasion, and Education Law §6530(3), negligence on more than one occasion. Incompetence includes a lack of the requisite knowledge or skill in the practice of the profession but does not require a showing of an act or omission constituting a breach of the duty of due care. Dhabuwala v. State Bd. For Professional Med. Conduct, 225 A.D.2d 209, 213 (3d Dept. 1996). Negligence involves the "failure to exercise the care that would be exercised by a

reasonably prudent licensee under the circumstances." Bogdan v. State Bd. For Professional Med. Conduct, 195 A.D.2d 86, 88 (3d Dept. 1993). The Department is not required to prove harm to a patient. Youssef v. State Bd. For Professional Med. Conduct, 89 A.D.3d 824, 825 (3d Dept. 2004). The Respondent's care of all four patients demonstrated a failure to exercise the required level of care and requisite knowledge or skill to practice the profession and was therefore negligent and incompetent.

The Hearing Committee also unanimously voted 3-0 that the Respondent's conduct constituted professional misconduct as defined in Educ. Law §6530(4), practicing the profession with gross negligence on a particular occasion, and Educ. Law §6530(6), practicing the profession with gross incompetence. Gross negligence involves a significant deviation from acceptable medical standards that creates the risk of grave consequence to the patient. Such conduct may result in a single act of negligence in egregious proportions or multiple acts of negligence that cumulatively are egregious. Post v. N.Y.S. Dept. of Health, 245 A.D.2d 985, 986 (3d Dept. 1997.) Gross incompetence involves an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. This conduct may consist of a single act of incompetence of egregious proportions or multiple acts of incompetence that cumulatively amount to egregious conduct. Post, 245 A.D.2d at 986; Minielly v. Commissioner of Health, 222 A.D.2d 750, 752 (3d Dept. 1995). The Respondent's failure to properly insert the catheter and provide oxygen supplementation to Patient A; properly discharge Patient B from the PACU; administer Patient C anesthetic drugs during her cesarean section procedure; and ensure proper monitoring of Patient D following extubation subjected these patients to extreme harm, including death for Patient A, potential intraoperative recall and PTSD for Patient C, pulmonary cardiac arrest for Patient B, and cardio-respiratory arrest for Patient D.

Penalty

In considering the full spectrum of penalties under PHL § 230-a, including revocation, suspension, probation, censure and reprimand, and the imposition of civil penalties, the Hearing Committee determined that the penalty of revocation of the Respondent's medical license is appropriate. The Hearing Committee considered the Respondent's long journey to become a physician in the United States that began in 1993. After practicing as a surgeon for many years in Russia and for several months in Israel, he secured a residency in Brooklyn and then a fellowship that led to a permanent internship in 1997, the year he brought his family here. Despite his many years as a physician practicing different specialties and in various states, including Ohio, New Jersey, and New York, the Hearing Committee nevertheless concludes the Respondent currently lacks the necessary due diligence and ability to try his level best to protect his patients, many of whom are high-risk, from harm. (Transcript, p. 640.)

The Hearing Committee noted that the Respondent pointed out his high accomplishments along the way, such as "top" medical student in Russia, "the best in the residency" at the University of Connecticut, and earning a score of "90" on the United States medical license examination, a score he said "Americans can only dream about. They can't even come close to my score." (Transcript, p. 636-639, 645.) The Hearing Committee concluded that this overconfidence transferred to his perception of his duties as an anesthesiologist, which he described as "(s)traightforward," "not a lot required," "I intubate the patient." (Transcript, p. 710.) The Hearing Committee believes these arrogant attitudes interfere with his ability to provide safe care to patients.

The Respondent claims he should be "recognized and appreciated" for how he "stepped up in a big way working significant overtime at WMC at the height of the coronavirus pandemic," but the Hearing Committee finds that his dangerous mindset led him to mistakenly believe he could safely intubate patients and administer them potent and potentially fatal drugs during this period despite being

so desperately sleep deprived. (Respondent's brief, p. 1; Transcript, p. 711-713.) The Hearing Committee noticed how the Respondent failed to consider the impact of such fatigue on his medical decisions or take responsibility for his patients' poor outcomes that included serious harm and even death. The Hearing Committee remains concerned about his inability to recognize his shortcomings and its implications on how he might respond when faced with other emergencies in the practice of medicine.

Order

Based upon the foregoing, IT IS HEREBY ORDERED THAT:

1. The first, second, third, fourth, and eighth specifications of professional misconduct set forth in the Statement of Charges are Sustained.

2. The fifth, sixth, and seventh specifications of professional misconduct set forth in the Statement of Charges are Dismissed.

3. The Respondent's license to practice medicine in the State of New York is hereby Revoked under PHL §230-a(4).

4. This Determination and Order shall be effective upon service on the Respondent in compliance with PHL §230(10)(h).

DATED: Albany, New York
October 29, 2021

[redacted]

Elisa E. Burns, M.D., Chairperson

Ramanathan Raju, M.D.
David F. Irvine, DHSc, P.A.

TO: Daniel Guenzburger, Associate Counsel
Bureau of Professional Medical Conduct
90 Church Street-4th Floor
New York, New York 10007

Jordan S. Fensterman, Esq.
Abrams, Fensterman, Fensterman, Eisman, Formato,
Ferrara, Wolf & Carone LLP
3 Dakota Drive
Suite 300
Lake Success, New York 11042

APPENDIX I

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

IN THE MATTER

OF

DMITRY ANATOLEVICH SHELCHKOV, M.D.

STATEMENT

OF

CHARGES

DMITRY ANATOLEVICH SHELCHKOV, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 9, 2009 by the issuance of license number 253970 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent is an anesthesiologist formerly employed at the Woodhull Medical Center, Brooklyn, NY. ("Woodhull") On or about July 2, 2020 the Respondent administered epidural anesthesia to Patient A, a 26-year-old female who had been admitted to Woodhull for induction of labor. The Respondent notes that on or about 21:36 he easily passed the catheter to a level of 10 cm. (from the skin) and the patient "tolerated the procedure well". Respondent further noted that he administered a test dose of lidocaine and epinephrine at 21:37 and that a minute later that he administered 100 mcg. of fentanyl via the epidural catheter and then 100 mcg. of fentanyl into the epidural infusion bag. The Patient reported difficulty breathing and was unresponsive and pulseless by 21:39. Patient A's baby was delivered by C-section at 21:45. Over the course of the next several hours the Patient sustained several cardiac arrests and expired at 23:51.

1. Respondent deviated from medically accepted standards in that he:
   a. Improperly inserted the epidural catheter.

b. Failed to wait an adequate period between the administration of the epidural test dose and administering further anesthetic medication.

2. Respondent failed to maintain an adequate record that accurately reflected his evaluation and treatment, including but not limited to noting anesthetic agents administered following the epidural test dose.
3. Respondent failed to appropriately administer bag-valve-mask ventilation/oxygen supplementation following the Patient's report of difficulty breathing.
4. Respondent knowingly and falsely represented that he inserted the epidural catheter to a depth of 10 cm., when, in fact, he knew that he had inserted the catheter far greater than 10 cm. Respondent intended to deceive.
5. Respondent concealed with the intent to deceive that he administered additional anesthetic medication to the patient following administration of the test dose. Respondent falsely reported to the Office of Professional Medical Conduct at an interview conducted on December 23, 2020 that he did not administer additional anesthetic agents after administering the epidural test dose.

B. On or about May 24, 2020 the Respondent administered general endotracheal anesthesia to Patient B, a 62-year-old female who underwent an open reduction internal fixation procedure ("ORIF") for a fractured right tibia. Patient B was at high risk for post-operative general anesthesia complications due a combination of factors, including a history of sleep apnea, COPD, obesity, smoking, and home oxygen dependence. Patient B could not be extubated at the conclusion of the surgical procedure due to oxygen desaturation. She remained intubated in the post-anesthesia care unit ("PACU") for two-and one-half hours. Respondent deviated from medically accepted standards in that he:

1. Failed to discuss and/or note having discussed with the Patient the relative risks of general anesthesia versus neuraxial anesthesia.

2. Failed to note a plan to address the Patient's high-risk of complications from general anesthesia.
3. Prematurely discharged the Patient from the PACU thirty minutes after she had been extubated.
4. Failed to document instructions for managing the patient following discharge from the PACU, including failing to note the need to have the patient transported to the hospital floor with monitoring, oxygen supplementation and accompanied during transit by an appropriately qualified health care practitioner. The Patient arrived on the hospital floor obtunded and in respiratory distress.

C. On or about May 22, 2020 Respondent administered epidural anesthesia to Patient C, a 31-year-old female who been admitted to Woodhull for induction of labor. Respondent recorded a negative test dose at 03:53. Within minutes of administering the test dose, the Patient reported numbness, shortness of breath and shortly thereafter became unresponsive. Respondent intubated the Patient at 04:03 and the Patient was then transferred to the operating room ("OR") for a C-section under general endotracheal anesthesia. Respondent deviated from medically accepted standards in that he:

1. Failed to administer anesthetic agents during the C-section to assure unconsciousness, amnesia and pain relief.
2. Failed to record vital signs in the anesthesia record for the first 25 minutes of the C-section, from 04:10 - 04:35.

D. On or about April 21, 2020, the Respondent administered general anesthesia to Patient D, a 47-year old male who underwent an exploratory laparotomy for a stab wound to the abdomen. The Patient remained in the OR following surgery because the PACU was being used for COVID 19 patients. The Respondent extubated Patient D and discontinued physiologic monitoring at 18:14. At 18:36 the patient went into

cardio/respiratory arrest. Respondent deviated from medically accepted standards in that he:

1. Failed to record vital signs and other medically significant events between 18:14 until 21:13.
2. Failed to adequately record medications administered between 18:14 to 21:13.
3. Failed to remain physically present in the OR following extubation of the Patient and/or failed to ensure that an appropriately qualified/credentialled health care practitioner was monitoring the patient during periods when Respondent was not physically present in the OR following extubation of the Patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

GROSS NEGLIGENCE

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

1. Paragraphs A, A1, A1(a), A1(b), A3, B, B3, C, C1and/or D and D3.

SECOND SPECIFICATION

GROSS INCOMPETENCE

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

2. Paragraphs A, A1, A1(a), A1(b), A3, B, B3, C, C1and/or D and D3.

THIRD SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

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

3. Paragraphs A, A1, A1(a), A1(b) A2, A3, B, B1, B2, B3, B4, C, C1, C2, D, D1, D2 and/or D3.

FOURTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

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

4. Paragraphs A, A1, A1(a), A1(b) A2, A3, B, B1, B2, B3, B4, C, C1, C2, D, D1, D2 and/or D3.

FIFTH and SIXTH 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:

5. A and A4.

6. A and A5.

SEVENTH SPECIFICATION

FALSE REPORT

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law § 6530(21) by willfully 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:

7. A and A4.

EIGHTH SPECIFICATION

FAILURE TO MAINTAIN RECORDS

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

8. Paragraphs A, A2, B, B, B1, B2, B4, C, C2, D, D1 and/or D2.

DATE: February 25, 2021
New York, New York

[redacted]

Henry Weintraub
Chief Counsel
Bureau of Professional Medical Conduct