STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

OFFICE OF PUBLIC HEALTH
Lloyd F. Novick, M.D., M.P.H.
Director
Diana Jones Ritter
Executive Deputy Director

December 14, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Cindy Fascia, Esq.
NYS Dept. of Health
Rm. 2438 Corning Tower
Empire State Plaza
Albany, New York 12237

Meiselman, Farber, Packman & Eberz, P.C.
by: Irving O. Farber, Esq., of Counsel
118 North Bedford Road
P.O. Box 151
Mt. Kisco, New York 10549

Effective date: 12/21/94

RE: In the Matter of Anna Piotrowski, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 94-153) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

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.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

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

IN THE MATTER

OF

ANNA PIATROWSKI, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER BPMC 94-153

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, WINSTON S. PRICE, M.D., EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on October 28, 1994 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) August 17, 1994 Determination finding Dr. Anna Piatrowski (Respondent) guilty of professional misconduct. The Office of Professional Medical Conduct (Petitioner) requested the review through a Notice which the Board received on August 30, 1994. The Respondent also requested a review but withdrew that request. James F. Horan served as Administrative Officer to the Review Board. Cindy Fascia, Esq. filed a brief for the Petitioner on October 3, 1994. Irving O. Ferber, Esq. filed a brief for the Respondent on October 4, 1994.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

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[1]Dr. Stewart and Dr. Sinnott participated in the Deliberations by telephone conference. Sumner Shapiro did not participate in the deliberations.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Office of Professional Medical Conduct charged the Respondent with gross negligence on one occasion, gross incompetence on one occasion and failure to maintain adequate records. The charges involved the treatment which the Respondent provided to a twenty-one month old male, whom, the record refers to as Patient A.

The Committee determined that the Respondent was guilty on all three charges. The Committee found that on August 23, 1991, the Respondent had ordered 1500 milligrams of Dilantin be administered to Patient A, who had suffered a seizure. The Committee found that the amount of Dilantin was an enormous overdose for a person of Patient A's size. As a result of the overdose Patient A died. The Committee found that the Respondent's action was a gross deviation from accepted medial practice, and that the Respondent did not know or check if the dose of Dilantin was appropriate for Patient A. The Committee also found that the Respondent's order demonstrated an egregious lack of knowledge and skill necessary to practice medicine safely.

The Committee voted to place the Respondent on probation for one and one-half years and ordered that the Respondent complete an evaluation and a course of retraining at the Physician Prescribed Educational Program (PPEP) at Syracuse. The Committee provided that if the Respondent failed to complete the requirements of PPEP evaluation and retraining within six months of the date of the Hearing Committee's Order, that the Respondent would be suspended from the practice of medicine until she completed the PPEP Phase II retraining course. The terms of the probation are set out in the Appendix to the Hearing Committee's Determination.

REQUESTS FOR REVIEW

The Petitioner asked for a review solely on the penalty. The Petitioner notes that the terms of probation do not provide for a practice monitor. The Petitioner contends that the Hearing Committee's penalty does not allow the Petitioner sufficient input into and oversight of the retraining process and that the penalty delegates authority unacceptably to PPEP without oversight by the Petitioner. The Petitioner requests that the Review Board modify the probation terms to include terms for a monitor during probation. The Petitioner attached recommended terms with the Petitioner's brief.

The Respondent opposes the request for a practice monitor. The Respondent states that, following the incident involving Patient A, the Respondent was monitored at St. Luke's Hospital in Newburgh for one year. The Respondent argues that the Hearing Committee's penalty already satisfies the Committee's concerns about what the Committee found to be the Respondent's serious lack of knowledge. The Respondent contends that the only purpose for a monitor would be to humiliate and embarrass the Respondent.

REVIEW BOARD DETERMINATION

The Review Board has considered the record below and the briefs which counsel have submitted.

The Review Board votes to sustain the Hearing Committee's determination finding the Respondent guilty of gross negligence, gross incompetence and failure to maintain adequate records in the case of Patient A. The Committee's Determination is consistent with their findings and conclusions concerning the overdose to Patient A. There was no challenge to the Determination on the charges.

The Review Board votes to sustain the Hearing Committee's Determination to place the Respondent on probation for one and one-half years and to order that the Respondent undergo a PPEP evaluation and any necessary retraining. The Board modifies the penalty to provide, that if the PPEP

Phase I Evaluation indicates that the Respondent is not a candidate for retraining, that the case is remanded to the Hearing Committee for additional deliberations on a Penalty.

The Review Board finds that the Hearing Committee's penalty is appropriate, in this case, to protect the public for the period during which the Respondent will be retraining. The Board sees no need to add a monitor to the period of probation.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

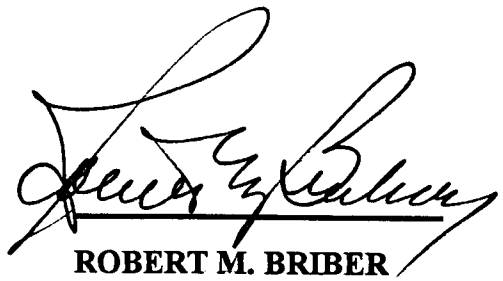
1. The Review Board **sustains** the Hearing Committee on Professional Medical Conduct's August 17, 1994 Determination finding Dr. Anna Piatrowski guilty of professional misconduct.
2. The Review Board **sustains** the Hearing Committee's Determination to place the Respondent on probation for one and one-half years and to order that the Respondent undergo the Phase I Evaluation and Phase II Retraining at the Physician Prescribed Education Program at Syracuse.
3. The Review Board **modifies** the Hearing Committee's Penalty to provide, that, if the Phase I Evaluation demonstrates that the Respondent is not a candidate for retraining, the case will be remanded to the Hearing Committee for further deliberations on a penalty.

ROBERT M. BRIBER
WINSTON S. PRICE, M.D.
EDWARD SINNOTT, M.D.
WILLIAM B. STEWART, M.D.

IN THE MATTER OF ANNA PIATROWSKI, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Anna Piatrowski.

DATED: Albany, New York
12/9 **, 1994**



ROBERT M. BRIBER

IN THE MATTER OF ANNA PIATROWSKI, M.D.

WINSTON S. PRICE, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Anna Piatrowski.

DATED: Brooklyn, New York

_____, 1994

WINSTON S. PRICE, M.D.

IN THE MATTER OF ANNA PIATROWSKI, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Anna Piatrowski.

DATED: Albany, New York
Nov 24, **1994**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF ANNA PIATROWSKI, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Anna Piatrowski.

DATED: Albany, New York
, **1994**

WILLIAM A. STEWART, M.D.

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

IN THE MATTER OF ANNA PIOTROWSKI, M.D.	**DETERMINATION** **AND** **ORDER** BPMC NO-94-153

SUMNER SHAPIRO, (Chair), **DANIEL W. SHERBER, M.D.** and **GERALD ANSELL, M.D.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to §230(10)(e) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., served as the Administrative Officer.

The Department of Health appeared by **CINDY M. FASCIA, ESQ.**, Associate Counsel. Respondent appeared by **MEISELMAN, FARBER, PACKMAN & EBERZ, P.C.**, by **IRVING O. FARBER, ESQ.** and **JAMES G. EBERZ, ESQ.**, of counsel.

Evidence was received, witnesses were sworn or affirmed and examined. Transcripts of the proceedings were made. After consideration of the record, the Hearing Committee issues this Determination and Order.

PROCEDURAL HISTORY

Date of Notice of Hearing:	April 6, 1994
Date of Service of Notice of Hearing:	April 15, 1994
Date of Statement of Charges:	April 6, 1994
Date of service of Statement of Charges:	April 15, 1994
Answer to Statement of Charges:	None Filed
Pre-Hearing Conference Held:	May 11, 1994
Hearing Held:	May 13, 1994 June 7, 1994 June 8, 1994
Received Petitioner's Brief, Proposed Findings of Fact, Conclusions and Recommendation:	July 12, 1994
Received Respondent's Proposed Findings of Fact and Law:	July 12, 1994
Witnesses called by the Petitioner, Department of Health:	Brett M. Macaluso, D.O. Pamela S. Lavrich, M.D. Kenneth J. Kroopnick, M.D. Steven Kanengiser, M.D.
Witnesses called by the Respondent, Anna Piotrowski:	Bruce Roseman, M.D. Barbara Hermance Mary Ellen Wright Franklin Guneratne, M.D. Anna M. Piotrowski, M.D. Paul M. Latonero, M.D.
Deliberations Held:	July 20, 1994

STATEMENT OF CASE

This case was brought pursuant to §230 of the Public Health Law of the State of New York (hereinafter P.H.L.). Respondent, ANNA PIOTROWSKI, M.D., (hereinafter "Respondent") is charged with three specifications of professional misconduct as delineated in §6530 of the Education Law of the State of New York (hereinafter Education Law). In this case, the Respondent is charged with: (1) professional misconduct by reason of practicing the profession with gross negligence on a particular occasion [1]; (2) professional misconduct by reason of practicing the profession with gross incompetence [2]; and (3) professional misconduct by reason of failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient [3].

The charges concern the medical care and treatment provided by Respondent to Patient A.

A copy of the Notice of Hearing and Statement of Charges is attached to this Determination and Order in Appendix I.

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[1] Education Law §6530(4) and First Specification of Petitioner's Exhibit # 1

[2] Education Law §6530(6) and Second Specification of Petitioner's Exhibit # 1

[3] Education Law §6530(32) and Third Specification of Petitioner's Exhibit # 1

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers in parentheses refer to transcript page numbers (T-) or exhibits in evidence. These citations of facts represent evidence and testimony found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence or testimony, if any, was considered and rejected in favor of the cited evidence. Unless otherwise noted, all Findings and conclusions herein were unanimous.

1. Respondent was authorized to practice medicine in New York State on October 14, 1977, by the issuance of license number 132837 by the New York State Education Department. (Petitioner's Exhibit #1; T-404)

2. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994. (Petitioner's Exhibit #1; T-404) Respondent has been a practicing pediatrician since 1978 with a private practice and as an attending physician in a pediatrics department of at least one hospital. (T-406)

3. The Respondent was served with the Notice of Hearing and Statement of Charges on April 15, 1994, by service on the offices of her attorney, Irving Farber, Esq. (Petitioner's Exhibit #2)

4. Patient A, a 21 month old male child, was admitted to the Emergency Room of St. Luke's Hospital, Newburgh, New York at approximately 7:40 A.M. on August 23, 1991. Patient A's mother stated that son had a temperature off and on for three days. On the morning of August 23, Patient A had a seizure at home, and was brought to St. Luke's Hospital. (Petitioner's Exhibit # 3, p. 1; T-414)

5. While in the Emergency Room, Patient A had further seizure activity. He was intubated and given Valium and Pentothal. (Petitioner's Exhibit # 3, pp. 1, 4)

6. Respondent was the pediatrician on call. She was called into the Emergency Room at St. Luke's Hospital to care for Patient A. (T-407-409) Respondent arrived at the Emergency Room between 8:15 A.M. and 8:20 A.M. (T-409; Petitioner's Exhibit # 3, p. 4) Respondent ordered Solu-Medrol and Rocephin for Patient A. Patient A was placed on a ventilator. (Petitioner's Exhibit # 3, pp. 1, 4)

7. Respondent decided that Patient A should be transferred to Westchester County Medical Center (hereinafter "WCMC"), the tertiary care center for the region. (T-416; Petitioner's Exhibit # 3, p. 4; T-22) Respondent called the Pediatric Intensive Care Unit (hereinafter "ICU") at WCMC to make arrangements for the transfer of Patient A. (T-419-420)

8. Dr. Brett M. Macaluso, the Senior Resident in the Pediatric ICU at WCMC, took Respondent's phone call. At WCMC, it was routinely the responsibility of the senior resident to take telephone calls from other hospitals regarding referrals, to discuss the particular case with the triage attending physician at WCMC, and to then advise the caller accordingly. Dr. Macaluso handled such calls, two or three times a week. (T-21-23)

9. Dr. Macaluso received Respondent's telephone call from St. Luke's Hospital regarding Patient A at approximately 8:45 A.M. (T-26; T-419) Respondent gave Dr. Macaluso a history for Patient A, including his vital signs, medication given, tests done and his weight which was estimated to be 10 kilograms. (T-26-28; T-420-422)

10. In August 1991, Dr. Steven Kanengiser was the clinical co-director of the pediatric ICU at WCMC. (T-188-189) He was present in the room when Dr. Macaluso took Respondent's call. (T-27; T-190) Dr. Macaluso discussed the case with Dr. Kanengiser. Dr. Kanengiser and Dr. Macaluso determined that they would be able to accept a transfer, and that Patient A could be transferred to WCMC as soon as transport could be arranged. (T-27; T-190; T-421)

11. Dr. Kanengiser and Dr. Macaluso also discussed whether any additional medical treatment for Patient A should be recommended in the interim, since the transport could take several hours. (T-27-28; T-63-67; T-190-193)

12. Dr. Kanengiser and Dr. Macaluso decided that a longer-acting anti-convulsant should be recommended to Respondent for Patient A. Patient A had been given Valium, which is a short-acting anti-convulsant. Given the length of time it would take for transport, a longer-acting seizure medication was recommended to avoid a seizure by the Patient during transport. Dilantin was recommended by them because it is a long-acting anti-convulsant which would not suppress the child's sensorium or mental status. (T-27; T-63-67; T-192-193; T-219) Dr. Kanengiser and Dr. Macaluso discussed the dosage and determined that the standard pediatric loading dose of 10 to 15 milligrams per kilogram of body weight should be recommended to Respondent for administration to Patient A. (T-27; T-192-193; T-221-222)

13. After his discussion with Dr. Kanengiser, Dr. Macaluso got back on the telephone with Respondent. Dr. Macaluso told Respondent that WCMC would accept transfer of Patient A. (T-27-28; T-421) Dr. Macaluso then discussed with Respondent the recommendation that Patient A receive a dose of Dilantin and that a nasogastric tube be placed. (T-27-28; T-423)

14. Neither Dr. Macaluso nor Dr. Kanengiser made any medical record in the ordinary course of practice or any contemporaneous notes regarding their recommendations of giving Dilantin to Patient A. (T-42-43; T-46; T-220)

15. Dr. Macaluso recommended that Respondent give Patient A, 15 milligrams of Dilantin for each kilogram of the child's weight. Respondent questioned the dose and Dr. Macaluso repeated the dosage amount to Respondent during their telephone conversation. (T-27-29)

16. In August 1991, Dr. Pamela S. Lavrich was in her second month of her internship at WCMC. (T-74-75) Dr. Lavrich was in the pediatric ICU when Dr. Macaluso recommended 15 milligrams of Dilantin per kilogram of the patient's weight. (T-74-75) Dr. Lavrich heard Dr. Macaluso say that the dose he recommended for this 10 kilogram child was 15 milligrams of Dilantin per kilogram of the child's weight, which was 150 milligrams. (T-75-76)

17. Dr. Kanengiser heard Dr. Macaluso say that the child should be given Dilantin at 15 milligrams per kilogram. For a 10 kilogram child, that's 150 milligrams. (T-221)

18. Dr. Macaluso did not tell Respondent to give Patient A 1,500 milligrams of Dilantin. Such a dose is far outside the range of any appropriate pediatric or adult

dose. (T-29-30; Respondent's Exhibit # A) Dr. Macaluso, during his residency at WCMC, was familiar with the drug Dilantin, its pediatric dosage and administration, and the side effects that could result from overdose or too rapid administration of this drug. (T-23-25)

19. Pediatricians, whether practicing in a hospital or a private setting, should be familiar with the concept that appropriate pediatric doses are frequently determined by the weight of the child. (T-193-194)

20. Respondent testified that Patient A weighed approximately 15 kilograms. (T-423; T-471) Respondent also testified that she believed that she was told to give "1,500 milligrams of IV Dilantin push". (T-420-423) The Respondent questioned the dose. (T-28; T-423)

21. Respondent gave the order that 1,500 milligrams of Dilantin be administered to Patient A by IV push over a 15 minute period. (Petitioner's Exhibit # 3, pp. 1, 4; T-423-427)

22. On August 23, 1991, Barbara Hermance was one of the registered nurse in the Emergency Room at St. Luke's Hospital. (T-285; T-288-290) Nurse Hermance received Respondent's order to administer 1,500 milligrams of Dilantin to Patient A by IV push over a 15 minute period. (Petitioner's Exhibit # 3, p. 4; T- 306-307; T-427) Nurse Hermance thought that "it seemed to be a lot of Dilantin". (T-311) She questioned Respondent twice about the dose of 1,500 milligrams, to make sure that this was in fact the dose that Respondent wanted, particularly for a child. (T-310-312; Respondent's Exhibits # B-1 & B-2)

23. After questioning Respondent twice about the dose of 1,500 milligrams of Dilantin for Patient A, and being told by Respondent that that was the dose to be given to Patient A, Nurse Hermance also questioned her supervisor, Mary Ellen Wright. She questioned the dose again because it seemed like a large dose to her, and she wanted some confirmation as to whether this was a large dose or not. (T-307; T-311-313; Respondent's Exhibits # B-1 & B-2)

24. At approximately 9:00 A.M., Nurse Hermance began administering the dose of Dilantin ordered by Respondent. (Petitioner's Exhibit # 3, pp. 1, 4) At some point during the administration of the drug, another nurse, Vivian Fitts, handled the administration of the Dilantin while Nurse Hermance attended to other matters. Respondent was present while the Dilantin was being administered to Patient A. (T. 307-308; Respondent's Exhibit B-1 & B-2)

25. At approximately 9:40 A.M., Patient A began seizing and went into respiratory arrest and then cardiac arrest. (Petitioner's Exhibit # 3, p. 5; T-308; Respondent's Exhibit B-1 & B-2) Approximately 1,000 milligrams of the 1,500 milligrams dose ordered by Respondent had been administered to Patient A when he arrested. (T-307-308; T-323-324)

26. A code was started and resuscitative efforts began at approximately 9:50 A.M. (T-326-327; T-332; Petitioner's Exhibit # 3, p. 5) At about 10:00 A.M., the transport team from WCMC arrived and found the child in arrest. The team from WCMC joined in the resuscitative effort. (Petitioner's Exhibit # 3, pp. 5-7; Petitioner's Exhibit # 4, pp. 4-5; T-326-327; T-332-335) At approximately 12:37 P.M., the team from WCMC took over Patient A's care, and he was transported to WCMC. (Petitioner's Exhibit # 3, p. 7; Petitioner's Exhibit # 4)

27. Patient A was admitted to WCMC at 2:15 P.M. On admission, his pupils were fixed and dilated, with no corneal reflexes and no spontaneous respirations. (Petitioner's Exhibit # 4, pp. 4-5) On August 31, 1991, Patient A was declared brain dead. During his stay in the Pediatric ICU at WCMC, Patient A remained in a deep coma, without spontaneous movements or response to deep painful stimuli. He had no cerebral or brainstem function. Patient A was pronounced dead at 4:50 P.M. on August 31, 1991. (Petitioner's Exhibit # 4, p. 2)

28. Dilantin is an anti-convulsant drug commonly used by pediatricians. It has been in common medical use as for at least twenty years. (T-23-24; T-104-107) Dilantin is used in pediatrics to treat children with seizures, for example, status epilepticus, idiopathic seizures and febrile seizures, which are common pediatric problems. Familiarity with the appropriate treatment for seizures, including familiarity with Dilantin, its dosage and its side effects, is basic knowledge in the practice of pediatrics. A pediatrician who expects to meet accepted standards of medical practice must have this knowledge. (T-106-107; T-111-113)

29. The major risks of Dilantin toxicity or overdose are cardiac arrest, ventricular fibrillation and respiratory and circulatory depression. (T- 24-25;T-108; Respondent's Exhibit A)

30. A pediatrician who expects to meet accepted standards of medical practice must check the appropriate dosage before administering that medication to a patient, if she is not familiar with a particular medication or its appropriate dosage under the circumstances. (T-111) The greater the toxicity of a drug, the greater the physician's obligation to verify dosage information before administration. (T-111)

31. In the Emergency Room of St. Luke's Hospital, there were several information sources available for Respondent to check the appropriate dose of Dilantin for Patient A. There were copies of the Physician's Desk Reference, (hereinafter "PDR") a standard reference source regarding drugs and medications, available to Respondent at the nursing station of the Emergency Room. (T-314-315; T-351; T-451) Respondent knew that copies of the PDR were available in the emergency room. She did not use or look at the PDR to check the appropriate dosage of Dilantin that should be given to Patient A. (T-451; T-468)

32. In addition to the copies of the PDR available to Respondent, there was also a computer in the Emergency Department of St. Luke's that could be used to obtain accepted doses and medications. Dosage information for Dilantin would have been available on the computer because it is an established medication and its use has not changed for a considerable period of time. Respondent did not make use of the computer to check the appropriate dosage of Dilantin that should be given to Patient A. (T-313-314; T-348-351)

33. Patient A's medical condition, prior to the administration of Dilantin, was of concern but was not immediately life-threatening. (T-116-117) Patient A was getting oxygen and he wasn't seizing. (T-34-37) Patient A's condition was stable enough that Respondent would have had time to look up the appropriate dosage information for Dilantin for Patient A. (T-36; T-117)

34. Respondent, at the time she was treating Patient A, knew the serious effects of Dilantin toxicity, including serious cardiovascular effects. She knew that a Dilantin overdose could be fatal. (T-457-458)

35. During the resuscitative efforts performed on Patient A at St. Luke's Hospital, "stat." Dilantin levels were ordered. The first level, drawn at 11:16 A.M. and reported at 12:08 P.M., was 75.0. (Petitioner's Exhibit # 3, p. 13) The therapeutic range for a child the weight of Patient A would be a level from 10 to 20. A level of 75.0 was an extremely high, toxic level. (T-113-115; T-443-444; Petitioner's Exhibit # 3, pp. 6, 13) A second Dilantin level was drawn at 12:57 P.M. and reported at 1:19 P.M. This level was 69.6, which is also an extremely high, toxic level. (T-113-115; Petitioner's Exhibit # 3, p. 15)

36. Once an overdose of Dilantin is given, there is no known antidote or treatment for that overdose and for the effects of Dilantin toxicity. (T-115; T-445; Respondent's Exhibit # A)

37. Patient A's cardiac arrest and his eventual death were caused by the overdose of Dilantin he received pursuant to Respondent's order. (T-116; T-177; T-457; T-461; Petitioner's Exhibit # 4)

38. The appropriate loading dose of Dilantin for a 10 kilogram child such as Patient A was from 10 to 15 milligrams per kilogram of the child's weight. The maximum appropriate dose for Patient A should have been 150 milligrams. (T-27-28; T-107-108; T-221-222; Respondent's Exhibit # A) Even if patient A weighed 15 kilograms and the loading dose was 15 to 20 milligrams, the maximum dose for Patient A would have been 300 milligrams. (T-423; T-24)[4]

[4] See also, Respondent's Exhibit # A (at p.1604, second column) "Pediatric Dose: Initially, 5 mg/kg/day in two or three equally divided doses, with subsequent dosage individualized to a maximum of 300 mg daily."

39. Respondent's order of 1,500 milligrams of Dilantin for Patient A was a serious deviation from accepted medical standards. (T-117-118) Respondent's order of 1,500 milligrams of Dilantin for Patient A was a very serious, life threatening error. (T-37-39)

40. Even if the physicians at WCMC had told Respondent that she should administer 1,500 milligrams of Dilantin to Patient A, it was a deviation from accepted standards of medical practice for Respondent to order this dose for Patient A. It is contrary to any basic medical judgment to administer that amount of Dilantin to a child the size of patient A. (T-122)

41. The standards of acceptable medical practice for the administration of Dilantin in pediatric situations is: administered at a rate of 0.5 milligram to 1 milligram per kilogram of the child's weight per minute. The dosage is usually given over a fifteen minute period for an adequate margin of safety. (T-123)

42. Respondent's order was for 1,500 milligrams of Dilantin by IV push over a period of fifteen minutes. This was a rate of 100 milligrams of Dilantin per minute. The appropriate and medically accepted dose for Patient A was 10 milligrams of Dilantin per minute to a maximum of 150 milligrams. A dose given at the rate of 100 milligrams per minute is ten (10) times the appropriate and medically accepted dose for Patient A and is an extremely high rate. Respondent's order for such a dose at such a rate constitutes a serious deviation from accepted standards of medical practice. It was a gross overdose. (T- 123-126)

43. Respondent made no notes in Patient A's medical record at St. Luke's Hospital regarding her care and treatment of this patient. (T-126; T-431; T-446-447; Petitioner's Exhibit # 3)

44. Respondent made no medical record in the ordinary course of practice or any contemporaneous notes regarding her telephone consultation with the physicians at WCMC. (T-126; T-446; Petitioner's Exhibit # 3)

45. Respondent failed to make an adequate medical record regarding her treatment of Patient A. Respondent's record keeping for Patient A did not meet accepted standards of medical practice. (T-126-127)

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the April 6, 1994, Statement of Charges, are sustained [5]:

Paragraph A.	:	(4 - 7; 9; 13; 15; 20; 21; 43; 44)
Paragraph A.1	:	(7; 9; 11; 13; 20; 21; 23)
Paragraph A.1.a	:	(21 - 23; 31 - 34)
Paragraph A.1.b	:	(12; 15; 17; 18; 20; 21; 23; 38 - 40; 42)
Paragraph A.1.c	:	(15; 17; 20; 21; 38 - 42)
Paragraph A.2	:	(43 - 44)

[5] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

The Hearing Committee further concludes that the following Specifications of Charges are sustained [6]:

FIRST SPECIFICATION: (Paragraphs: A, A.1.a, A.1.b and A.1.c)

SECOND SPECIFICATION: (Paragraphs: A, A.1.b and A.1.c)

THIRD SPECIFICATION: (Paragraphs: A and A.2.)

DISCUSSION

The Respondent is charged with three specifications alleging professional misconduct within the meaning of §6530 of the Education Law. §6530 of the Education Law sets forth a number and variety of forms or types of conduct which constitutes professional misconduct. However, §6530 of the Education Law does not provide definitions of the types of misconduct charged in this matter.

During the course of its deliberations on these charges, the Hearing Committee consulted a memorandum, prepared by Peter J. Millock, General Counsel for the New York State Department of Health, dated February 5, 1992. This document, entitled: Definitions of Professional Misconduct under the New York Education Law, (hereinafter "Misconduct Memo"), sets forth suggested definitions for inter alia gross negligence and gross incompetence.

The following definitions from the Misconduct memo were used by the Hearing Committee during its deliberations:

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[6] The citations in parentheses refer to the Factual Allegations which support each Specification.

Gross Negligence is the failure to exercise the care that would be exercised by a reasonably prudent physician under the circumstances, and which failure is manifested by conduct that is egregious or conspicuously bad. Gross Negligence may consist of a single act of negligence of egregious proportions.

Gross Incompetence is an unmitigated lack of the skill or knowledge necessary to perform an act undertaken by the licensee in the practice of medicine. Gross Incompetence may consist of a single act of incompetence of egregious proportions.

Egregious means a conspicuously bad act or an extreme, dramatic or flagrant deviation from standards.

With regard to the testimony presented herein, including Respondent's, the Hearing Committee evaluated each witness for possible bias. The witnesses were also assessed according to his or her training, experience, credentials, demeanor and credibility.

Dr. Kenneth J. Kroopnick presented an impartial approach with no professional association either with the Respondent or with the physicians at WCMC. Dr. Brett M. Macaluso and Dr. Steven Kanengiser presented credible testimony, although not totally free of self-interest. Dr. Pamela S. Lavrich was credible and appeared free of bias. The Respondent, Dr. Piotrowski, offered mostly credible testimony, although she obviously had the greatest amount of interest in the results of these proceedings. Whether the Respondent really was told 1,500 milligrams, as opposed to 150 milligrams, would not have changed the Hearing Committee's Order and Determination.

Ms. Mary Ellen Wright's testimony was found to be mostly self-protecting and not credible, especially when compared to Ms. Barbara Hermance who was more forthright. The remaining witnesses were more in the form of character and competence of the Respondent testimony and was taken into consideration and evaluated accordingly.

With regard to a finding of medical misconduct, the Hearing Committee first assessed Respondent's medical care of the Patient, without regard to outcome but rather as a step-by-step assessment of patient situation, followed by medical response. Where medical misconduct has been established, the outcome may be, but need not be, relevant to penalty, if any. Patient harm need not be shown to establish negligence in a proceeding before the Board for Professional Medical Conduct.

Using the above definitions and understanding, including the remainder of the Misconduct memo, the Hearing Committee, unanimously concludes that the Department of Health has shown by a preponderance of the evidence that Respondent's conduct constituted professional misconduct under the laws of New York State. The Department of Health has met its burden of proof as to the three specifications of misconduct contained in the April 6, 1994 Statement of Charges and the Hearing Committee, unanimously votes to sustain the three Charges.

The rationale for the Hearing Committee's conclusions is set forth below.

Gross Negligence

The record clearly establishes that Dr. Piotrowski failed to meet the appropriate standards of care with respect to Patient A. Dr. Piotrowski ordered 1,500 milligrams of Dilantin for Patient A, who weighed approximately 10 kilograms. 1,500 milligrams

of Dilantin for a 10 kilogram Patient is an enormous overdose and a gross deviation from accepted medical practice. The risks of Dilantin overdose or toxicity include cardiac arrest, ventricular fibrillation and respiratory and circulatory depression. There is no known effective treatment for Dilantin overdose. Accepted standards of medical practice require that a physician be or become familiar with Dilantin toxicity and calculations of loading doses, before it is ordered or administered. Dr. Piotrowski did not know or check if 1,500 milligrams of Dilantin was an appropriate dose for Patient A. Dr. Piotrowski's deviation from accepted medical standards in her treatment of Patient A was more than a mere error or medical mistake, it was of egregious proportions. Dr. Piotrowski was grossly negligent in her medical care of Patient A.

Gross Incompetence

In August 1991, Dr. Piotrowski had been authorized to practice medicine in New York State for approximately 14 years. Dr. Piotrowski had been a practicing pediatrician for approximately 13 years. In addition to the discussion above under Gross Negligence, the following is noted. Dilantin is a commonly used drugs in pediatrics. Seizures are common child hood occurrences seen by pediatricians. Dilantin is an anti-convulsant drug used by pediatricians to treat or stabilize children who have or are having seizures. Accepted standards of medical practice require that a physician practicing as a pediatrician have knowledge to effectively treat children with seizures. Accepted standards of medical practice require that a pediatrician be familiar with Dilantin, its proper dosage and calculations. Accepted standards of medical practice require that a physician who is not familiar with a medication or its proper dosage inform herself by checking the product information for the appropriate

dosage, administration and side effects. Dr. Piotrowski did not know that 1,500 milligrams of Dilantin was a grossly excessive and inappropriate dose for a person the size of Patient A. Dr. Piotrowski's order that 1,500 milligrams be administered over a 15 minute period was a gross overdose and at a grossly excessive rate. Said order demonstrates a serious lack of the knowledge and skill necessary to practice medicine safely. It was an egregious lack of knowledge to have ordered 1,500 milligrams to be administered over a 15 minute period. When faced with questioning by Nurse Hermance, it was additionally incompetent for Dr. Piotrowski not to have checked her order before its administration. Dr. Piotrowski's unmitigated lack of knowledge to care for this Patient was compounded by her failure to know that she did not know, which should have resulted in looking up the information. Dr. Piotrowski's deviation from accepted medical standards in her treatment of Patient A was more than a lapse of knowledge, it was of egregious proportions. Dr. Piotrowski was grossly incompetent in her medical care of Patient A.

Failure to Maintain Adequate Records

§ 6530(32) of the Education Law requires a licensee (physician) to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Dr. Piotrowski was charged with failing to document a telephone consultation in Patient A's hospital record. Dr. Piotrowski was not charged with not making one single note in the St. Luke's Hospital record for this patient. Dr. Piotrowski did not document her telephone consultation with Westchester County Medical Center. Therefore, the medical records of Patient A did not accurately reflect the evaluation and treatment of the patient.

DETERMINATION AS TO PENALTY

The Hearing Committee, pursuant to the Findings of Fact, Conclusions of Law and Discussion set forth above, unanimously determines as follows:

1. Dr. Piotrowski shall be placed on probation for a period of one and a half (1 ½) year from the effective date of this Determination and Order and comply with the terms of probation contained in Appendix II; and

2. Dr. Piotrowski must complete an evaluation and a course of re-training by attending and completing the Phase I Evaluation of the Physician's Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center at Syracuse [7]; and

3. After completion of Phase I of the PPEP, Dr. Piotrowski must attend and successfully complete Phase II of the PPEP [8]; and

4. In the event Dr. Piotrowski has not complied with both of the above paragraphs within six (6) months of the effective date of this Determination and Order, her license to practice medicine in New York State shall THEN be suspended until she has successfully completed the aforementioned Phase II re-training course.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to §230-a of the P.H.L., including:

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[7] Department of Family Medicine, 479 Irving Avenue, No. 200, Syracuse, New York, 13210.

[8] Or an equivalent program, approved by the Office of Professional Medical Conduct.

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The record in this case clearly establishes that Respondent committed Gross Negligence and Gross Incompetence in the care and treatment of Patient A. Respondent demonstrated deficiencies in her knowledge, skills and judgment in providing medical care to Patient A. However, the Hearing Committee believes that Respondent is capable of learning from her errors and is capable of rehabilitation. In arriving at a determination as to penalty, the Hearing Committee has taken into consideration the two courses already taken by the Respondent, as well as, the one year prescription and record monitoring by St. Lukes hospital. (T-436-437)

The Hearing Committee considers Respondent's misconduct to be very serious and is concerned for the health and welfare of patients in New York State. Therefore, the Hearing Committee determines the above to be the appropriate sanctions under the circumstances.

ORDER

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

1. The First, Second and Third Specifications of professional misconduct contained in the Statement of Charges (Petitioner's Exhibit #1) are **SUSTAINED**; and

2. Respondent is placed on probation for a period of one and a half (1½) year from the effective date of this Determination and Order; and

3. Respondent must successfully complete a Phase I and a Phase II re-training as more fully discussed in this Determination and Order; and

4. In the event said re-training is not completed within six (6) months of the effective date of this Determination and Order, Respondent's license to practice medicine in New York State shall THEN be suspended until she has successfully completed the re-training; and

5. The complete terms of probation are attached to this Determination and Order in Appendix II and are incorporated herein; and

6. Respondent's re-training and probation shall be supervised by the Office of Professional Medical Conduct.

DATED: **Albany, New York**
August, 16 **1994**

SUMNER SHAPIRO, Chair

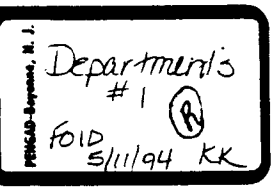
DANIEL W. SHERBER, M.D.
GERALD ANSELL, M.D.

To: Cindy M. Fascia, Esq.,
Associate Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
Corning Tower Building, Room 2429
Empire State Plaza
Albany, New York 12237-0032

Meiselman, Farber, Packman & Eberz, P.C.
by: Irving O. Farber, Esq., of counsel
118 North Bedford Road,
P.O. Box 151
Mt. Kisco, NY, 10549

APPENDIX I

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



IN THE MATTER	
OF	NOTICE
ANNA PIOTROWSKI, M.D.	OF
	HEARING

TO: ANNA PIOTROWSKI, M.D.
162 North Plank Road
Newburgh, New York 12550

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 13th day of May, 1994, at 10:00 o'clock in the forenoon of that day at the Ramada Inn (Airport), 1055 Union Avenue, Newburgh, New York, 12550, and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You

shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), 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 Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall

be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 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.

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 THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York

April 6, 1994

Peter D. Van Buren

PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to: CINDY M. FASCIA
Associate Counsel
Bureau of Professional
Medical Conduct
Corning Tower Building
Room 2429
Empire State Plaza
Albany, New York 12237-0032
Telephone No.: (518) 473-4282

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

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
ANNA PIOTROWSKI, M.D.	:	CHARGES

----------X

ANNA PIOTROWSKI, M.D., the Respondent, was authorized to practice medicine in New York State on October 14, 1977 by the issuance of license number 132837 by the New York State Education Department. Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994 from 162 North Plank Road, Newburgh, New York 12550.

FACTUAL ALLEGATIONS

A. Respondent provided medical treatment to Patient A, (identified in the Appendix) a 21 month old child, on August 23, 1991 at St. Luke's Hospital, Newburgh, New York.

1. Respondent, after her telephone consultation with a physician from Westchester County Medical Center, believed that said physician had recommended that 1500 mg. of Dilantin be administered to Patient A.

a. Respondent failed to verify whether a dose of 1500 mg. of Dilantin was appropriate for Patient A prior to ordering that said dose be administered.

b. Respondent ordered that 1500 mg. of Dilantin be administered to Patient A, which dose was excessive for Patient A.

c. Respondent ordered that 1500 mg. of Dilantin be administered to Patient A intravenously over a fifteen minute period, which dose was excessive given over said time interval.

2. Respondent failed to document said telephone consultation in Patient A's hospital record.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing the profession of medicine with gross negligence on a particular occasion under N.Y. Educ. Law §6530(4) (McKinney Supp. 1994) in that Petitioner charges:

1. The facts in Paragraphs A and A.1(a), and/or A.1(b), and/or A.1(c).

SECOND SPECIFICATION

PRACTICING WITH GROSS INCOMPETENCE

Respondent is charged with practicing the profession of medicine with gross incompetence under N.Y. Educ. Law §6530(6) (McKinney Supp. 1994) in that Petitioner charges:

2. The facts in Paragraphs A and A.1(b) and/or A.1(c).

THIRD SPECIFICATION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(32) (McKinney Supp. 1994) by reason of her failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient, in that Petitioner charges:

3. The facts in Paragraphs A and A.2.

DATED: Albany, New York
April 6, 1994

Peter D. Van Buren

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

APPENDIX II

TERMS OF PROBATION

1. Dr. Piotrowski shall conduct herself in all ways in a manner befitting her professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by her profession.

2. Dr. Piotrowski shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Dr. Piotrowski shall submit prompt written notification to the Board addressed to the Director, Office of Professional Medical Conduct, Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, residence or telephone number, within or without New York State.

4. In the event that Dr. Piotrowski leaves New York to reside or practice outside the State, Dr. Piotrowski shall notify the Director of the Office of Professional Medical Conduct (hereinafter "OPMC") in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of her departure and return. Periods of residency or practice outside New York shall toll the probationary period, which shall be extended by the length of residency or practice outside New York.

5. Dr. Piotrowski shall have quarterly meetings with an employee or designee of the OPMC during the period of probation. During these quarterly meetings Dr. Piotrowski's professional performance may be reviewed by having a random selection of office records, patient records and hospital charts reviewed.

6. Dr. Piotrowski shall submit quarterly declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation and, if not, the specifics of such non-compliance. These shall be sent to the Director of the OPMC at the address indicated above.

7. Dr. Piotrowski shall submit written proof to the Director of the OPMC at the address indicated above that she has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Dr. Piotrowski elects not to practice medicine as a physician in New York State, then she shall submit written proof that she has notified the New York State Education Department of that fact.

8. If there is full compliance with every term set forth herein, Dr. Piotrowski may practice as a physician in New York State in accordance with the terms of probation; provided, however, that on receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Dr. Piotrowski pursuant to New York Public Health Law §230(19) or any other applicable laws.

9. Dr. Piotrowski must complete an evaluation and a course of re-training by attending and completing the Phase I Evaluation of the Physician's Prescribed Educational Program (PPEP) of the Department of Family Medicine, SUNY Health Science Center at Syracuse and the Department of Medical Education at St. Joseph's Hospital and Health Center at Syracuse.

10. Results of the Phase I Evaluation will be forwarded to the OPMC.

11. OPMC will then refer Dr. Piotrowski to the designated facility for Phase II retraining. After completion of Phase I of the PPEP, Dr. Piotrowski must attend and successfully complete Phase II of the PPEP.

12. Dr. Piotrowski shall be on probation for a period of one and a half (1½) year from the effective date of the Determination and Order.

13. Dr. Piotrowski's probation, Phase I and Phase II of the PPEP shall be supervised by the OPMC.