New York State Board for Professional Medical Conduct

Corning Tower • Empire State Plaza • Albany, NY 12237 • (518) 474-8357

Barbara A. DeBuono, M.D., M.P.H.
Commissioner of Health

Charles J. Vacanti, M.D.
Chair

April 1, 1996

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

David F. Rosner, M.D.
214 Church Street
Carthage, New York 13619

Re: License No. 153527

Dear Dr. Rosner: Effective Date April 4,1996

Enclosed please find ***corrected*** Order #BPMC 96-69 of the New York State Board for Professional Medical Conduct. This Order and any penalty provided therein goes into effect upon receipt of this letter or seven (7) days after the date of this letter, whichever is earlier.

I sincerely apologize for any inconvenience caused by this error. Please contact Timothy Mahar if you have any questions or need additional information.

Sincerely,

Charles J. Vacanti, M.D.
Chair
Board for Professional Medical Conduct

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER :

OF : ORDER

DAVID F. ROSNER, M.D. : BPMC #96-69

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Upon the application of DAVID F. ROSNER, M.D. (Respondent) for Consent Order, which application is made a part hereof, it is

ORDERED, that the application and the provisions thereof are hereby adopted and so ORDERED, and it is further

ORDERED, that this order shall take effect as of the date of the personal service of this order upon Respondent, upon receipt by Respondent of this order via certified mail, or seven days after mailing of this order by certified mail, whichever is earliest.

SO ORDERED,

DATED: 3/22/96

Charles J. Vacanti, M.D.
Chairperson
State Board for Professional
Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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: APPLICATION

IN THE MATTER

: FOR

OF

: CONSENT

DAVID F. ROSNER, M.D.

: ORDER

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STATE OF NEW YORK)
ss.:
COUNTY OF JEFFERSON)

DAVID F. ROSNER, M.D., being duly sworn, deposes and says:

That on or about May 11, 1983, I was licensed to practice as a physician in the State of New York, having been issued License No. 153527 by the New York State Education Department.

I am currently registered with the New York State Education Department to practice as a physician in the State of New York for the period January 1, 1995 through May 31, 1996.

I understand that the New York State Board for Professional Medical Conduct has charged me with four specifications of professional misconduct.

A copy of the statement of charges is annexed hereto, made a part hereof, and marked as Exhibit "A".

I admit guilt to paragraphs A and A(2), A and A(3) and A and A(4) of the first specification and paragraphs B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), and C and C(1) of the third specification, in full satisfaction of the charges against me.

I hereby agree to a penalty of a three year suspension of my medical license. Said suspension shall be stayed, and I will serve a three year probation in accordance with the terms set forth in Appendix B hereto. The period of probation will commence upon the service of the final order upon me.

I hereby make this Application to the State Board for Professional Medical Conduct (the Board) and request that it be granted.

I understand that, in the event that this Application is not granted by the Board, nothing contained herein shall be binding upon me or construed to be an admission of any act of misconduct alleged or charged against me, such Application shall not be used against me in any way and shall be kept in strict confidence during the pendency of the professional misconduct disciplinary proceeding; and such denial by the Board shall be made without prejudice to the continuance of any disciplinary proceeding and the final determination by the Board pursuant to the provisions of the Public Health Law.

I agree that, in the event the Board grants my Application, as set forth herein, an order of the Chairperson of the Board shall be issued in accordance with same.

I am making this Application of my own free will and accord and not under duress, compulsion or restraint of any kind or manner.

David F. Rosner M.D.

David F. Rosner, M.D.
RESPONDENT

Sworn to before me this
11th day of March, 1996.

Heather B Filson
NOTARY PUBLIC

HEATHER B FILSON
Notary Public in the State of New York
Qualified in Jefferson County No. 4937670
My Commission Expires October 17, 19[illegible]

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

IN THE MATTER : APPLICATION
OF : FOR
DAVID F. ROSNER, M.D. : CONSENT
: ORDER

The undersigned agree to the attached application of the Respondent and to the proposed penalty based on the terms and conditions thereof.

DATE: 3-11-96

DAVID F. ROSNER, M.D.
Respondent

DATE: 2.20.96

CARLTON F. THOMPSON, ESQ.
OF COUNSEL TO LEVENE,
GOULDIN & THOMPSON, LLP
Attorneys for Respondent

DATE: March 15, 1996

TIMOTHY J. MAHAR
ASSISTANT COUNSEL
Bureau of Professional
Medical Conduct

DATE: March 15, 1996

ANNE F. SAILE
ACTING DIRECTOR
Office of Professional Medical Conduct

DATE: 20 March 1996

CHARLES J. VACANTI, M.D.
CHAIRPERSON
State Board for Professional Medical Conduct

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
DAVID F. ROSNER, M.D.	:	CHARGES

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DAVID F. ROSNER, M.D., the Respondent, was authorized to practice medicine in New York State on March 11,1983, by the issuance of license number 153527 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. From approximately January 16, 1990 through February 11, 1991, Respondent provided medical care to Patient A (patients are identified in Appendix A hereto) at Respondent's office at 214 Church Street, Carthage, New York (hereinafter office) and at the Carthage Area Hospital, Carthage, New York, including attempting a laparoscopic cholecystectomy and performing an open cholecystectomy on February 4, 1991. Respondent's medical care and treatment of Patient A deviated from accepted standards of medical care in the following respects:

1. Respondent attempted to perform a laparoscopic cholecystectomy on Patient A which was not indicated.

2. Respondent failed to properly place the second trocar during the attempted laparoscopic cholecystectomy, injuring Patient A.

3. During the subsequent open cholecystectomy/ laparotomy procedure, Respondent failed to ascertain and/or address in a timely manner Patient A's bleeding, which had resulted from the attempted laparoscopic cholecystectomy.

4. Respondent performed an open cholecystectomy on Patient A without determining the extent of the injury caused to Patient A during the attempted laparoscopic cholecystectomy.

B. From approximately November 14, 1990 through May 6, 1991, Respondent provided medical care to Patient B at his office and at the Carthage Area Hospital, including attempting a laparoscopic cholecystectomy and performing a cystostomy and an open cholecystectomy, among other procedures, on March 19, 1991. Respondent's medical care and treatment of Patient B deviated from accepted standards of medical care in the following respects:

1. Respondent failed to catheterize Patient B prior to attempting the laparoscopic cholecystectomy.

2. Respondent failed to perform an adequate physical examination of Patient B's abdomen, which would

have disclosed a distended bladder, prior to inserting the verres needle and the trocar at the umbilicus during the attempted laparoscopic cholecystectomy.

3. Respondent inserted a trocar into Patient B's bladder during the attempted laparoscopic cholecystectomy procedure.

4. Respondent inserted a second trocar into Patient B's bladder during the attempted laparoscopic cholecystectomy procedure.

5. Respondent failed to recognize that the initial trocar which he had inserted at Patient B's umbilicus during the attempted laparoscopic cholecystectomy had actually been inserted into the bladder, prior to Respondent's negligently inserting a second trocar into Patient B's bladder.

C. From approximately October 17, 1990 through December 16, 1991, Respondent provided medical care to Patient C at his office and at the Carthage Area Hospital, including performing a diverting colostomy in Patient C's sigmoid colon on March 5, 1991 after diagnosing an acute sigmoid diverticulitis with partial obstruction. Respondent's medical care and treatment of Patient C deviated from accepted standards of medical care in the

following respects:

1. On May 7, 199[illegible], Respondent closed Patient C's colostomy at the abdominal wall without resecting the diseased colon segment, which was contraindicated.

D. From approximately May 23, 1990 through August 6, 199[illegible], Respondent provided medical care to Patient D at his office and at the Carthage Area Hospital, including performing a cholecystectomy on Patient D on May 25, 1990. Respondent's medical care and treatment of Patient D deviated from accepted standards of medical care in the following respects:

1. Respondent performed a cholecystectomy on Patient D which was contraindicated in circumstances in which Respondent was aware that Patient D had a large right breast mass. Respondent failed to determine the extent, if any, of Patient D's right breast disease and the relationship, if any, of the right breast symptoms to Patient D's right upper quadrant symptoms prior to performing the cholecystectomy.

E. From approximately January 14, 1991 through February [illegible], 1991, Respondent provided medical care to Patient E at his office and at the Carthage Area Hospital, including performing a laparoscopic cholecystectomy on January 30, 1991. Respondent's

medical care and treatment of Patient E deviated from accepted standards of medical care in the following respects:

1. Respondent performed a laparoscopic cholecystectomy on Patient E which was not indicated.

F. From approximately November 20, 1989 through January 21, 1991, Respondent provided medical care to Patient F at his office and at the Carthage Area Hospital, including performing a laparoscopic cholecystectomy on November 21, 1990. Respondent's medical care and treatment of Patient F deviated from accepted standards of medical care in the following respects:

1. Respondent performed a laparoscopic cholecystectomy on Patient F which was not indicated.

G. From approximately January 25, 1990 through October 24, 1990, provided medical care to Patient G at his office and at the Carthage Area Hospital, including performing a cholecystectomy on July 18, 1990. Respondent's medical care and treatment of Patient G deviated from accepted standards of medical care in the following respects:

1. Respondent performed a cholecystectomy on Patient G which was not indicated.

SPECIFICATIONS OF CHARGES

FIRST SPECIFICATION

PRACTICING WITH GROSS NEGLIGENCE

ON A PARTICULAR OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(4) (McKinney Supp. 1995; formerly N.Y. Educ. law §6509 (2)) by reason of his practicing the profession of medicine with gross negligence on a particular occasion, in that Petitioner charges the following:

1. The facts in paragraphs A and A(2), A and A(3), A and A(4), B and B(5), and/or C and C(1).

SECOND SPECIFICATION

PRACTICING THE PROFESSION WITH

GROSS INCOMPETENCE

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(6) (McKinney Supp. 1995; formerly N.Y. Educ. Law §6530(2)) by reason of his practicing the profession of medicine with gross incompetence, in that Petitioner charges the following:

2. The facts in paragraphs A and A(2), A and A(3), A and A(4), B and B(5), and/or C and C(1).

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE

ON MORE THAN ONE OCCASION

Respondent is charged with professional misconduct under N.Y. Educ. Law §6530(3)(McKinney Supp. 1995; formerly N.Y. Educ. Law §6509[2]) by reason of his practicing the profession of medicine with negligence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

3. The facts in paragraphs A and A(1), A and A(2), A and A(3), A and A(4), B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), C and C(1), D and D(1), E and E(1), F and F(1), and/or G and G(1).

FOURTH SPECIFICATION

PRACTICING WITH INCOMPETENCE ON

MORE THAN ONE OCCASION

Respondent is charged with profession misconduct under N.Y. Educ. Law §6530(5)(McKinney Supp. 1995; formerly N.Y. Educ. Law §6509[2]) by reason of his practicing his profession of medicine with incompetence on more than one occasion, in that Petitioner charges that Respondent committed two or more of the following:

4. The facts in paragraphs A and A(1), A and A(2), A and A(3), A and A(4), B and B(1), B and B(2), B and B(3), B and B(4), B and B(5), C and C(1), D and D(1), E and E(1), F and F(1), and/or G and G(1).

DATED: , 1995
Albany, New York

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

EXHIBIT "B"

TERMS OF PROBATION

1. Respondent will personally meet with a member of the Office of Professional Medical Conduct staff on a random basis at the discretion of the Director of the Office of Professional Medical Conduct or designee.

2. Respondent will conform fully:

   a. to the professional standards of conduct imposed by law and by his profession

   b. with all civil and criminal laws, rules and regulations.

3. Respondent will notify the Office of Professional Medical Conduct of:

   a. any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within thirty days of each action;

   b. any and all changes in personal and professional addresses and telephone numbers and facility affiliations, within 30 days of such changes. This will including any change in practice location, within or outside of the State of New York. The date of departure from the State of New York, and the date of return, if any, must be reported in writing.

   Failure to notify the Office of Professional Medical Conduct of any of the above will be considered a violation of probation.

4. Respondent will maintain legible and complete medical records which accurately reflect evaluation and treatment of patients. Records will contain a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment. In cases of prescribing, dispensing, or administering of controlled substances, the medical record will contain all information required by state rules and regulations regarding controlled substances.

5. So long as there is full compliance with every term herein set forth, Respondent may continue to practice his or her profession in accordance with the terms of probation. Upon receipt of evidence of non compliance with, or any violation of these terms, the Director of the Office of Professional Medical Conduct and/or the Board may initiate a violation of probation proceeding and/or any such other proceeding against Respondent as may be authorized by law.

a. Respondent shall assume and bear all costs related to compliance with the terms of probation.

7. If the Respondent does not practice medicine in the State of New York, the probation period shall be tolled and the period will then be extended by the length of the period outside of New York. Any terms of probation which were not fulfilled while Respondent was in New York State, must be fulfilled upon return to New York State.

8. Respondent's practice of medicine during the period of probation shall be monitored by a physician monitor, board certified in surgery, approved in advance, in writing, by the Director of the Office of Professional Medical Conduct or designee. It shall be Respondent's responsibility to locate a physician willing to serve in such a capacity and who is approved by the Director of the Office of Professional Medical Conduct. Respondent may not practice medicine until an approved practice monitor and monitoring program is in place. Any practice of medicine prior to the submission and approval of a proposed monitor will be determined to be a violation of probation.

a. On a quarterly basis, the practice monitor shall review a random selection of the office and hospital records of not less than 20 surgical cases, which Respondent performed over the previous three months. The practice monitor shall select the 20 cases to be reviewed from a written list of names of all of Respondent's surgical patients during the previous three months. Respondent shall prepare the list and a brief description of the type of surgery performed on each patient, and shall obtain from the hospital(s) at which Respondent performed surgery during the preceding three months a verification of the list as including all of the names of patients upon whom Respondent performed surgery during that period. Following each such review, the practice monitor shall meet with the Respondent in person to discuss the cases reviewed. The practice monitor shall then submit a written report to the Director of the Office of Professional Medical Conduct, which shall include an opinion as to whether Respondent's medical practice was conducted in accordance with generally accepted standards of professional medical care. Any perceived deviation from accepted standards of medical care or refusal to cooperate with the practice monitor shall be immediately reported to the Office of Professional Medical Conduct by the practice monitor. The practice monitor shall submit to the Office of Professional Medical Conduct the list identifying all of Respondent's surgical patients, during the preceding three months with his or her report.

b. Following the first year of probation and upon application by Respondent, the Director of the Office of Professional Medical Conduct or her designee may in her sole discretion modify the requirement that Respondent meet in person with the practice monitor every three months to discuss the cases reviewed, and in lieu thereof, may permit the practice monitor and Respondent to discuss the cases by telephone. Following the second year of probation and upon application by Respondent, the Director of the Office of Professional Medical Conduct or her designee, may in her sole discretion modify the requirement that Respondent's surgical cases be reviewed on a quarterly basis and in lieu thereof require a less frequent monitoring term.

c. Any change in practice monitor must be approved in writing, in advance, by the Office of Professional Medical Conduct.

d. All expenses associated with monitoring, including fees of the monitoring physician, shall be the sole responsibility of the Respondent.

e. It is the responsibility of the Respondent to ensure that the reports of the practice monitor are submitted in a timely manner. The failure of the practice monitor to submit the required reports on a timely basis will be considered a possible violation of the terms of probation.

f. Respondent must maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230-f [sic] of the Public Health Law. Proof of coverage shall be submitted to the Director or designee prior to the placement of a practice monitor.