STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

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

Karen Schimke
Executive Deputy Commissioner

August 29, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Anthony Scher, Esq.
Wood & Scher
The Harwood Building
14 Harwood Court
Scarsdale, New York 10583

Terrence Sheehan, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

Edward M. Birdsong, M.D.
1 Spruce Drive
Patchogue, New York 11772

RE: In the Matter of Edward M. Birdsong, D.O.

Dear Mr. Scher, Mr. Sheehan and Dr. Birdsong:

Enclosed please find the Determination and Order (No. 95-194) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
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.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "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 all action 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:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

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

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

Sincerely,

Tyrone T. Butler/klw

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

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

IN THE MATTER OF EDWARD M. BIRDSONG, D.O.	DETERMINATION AND ORDER BPMC-95-194

GERALD BRODY, M.D., Chairperson, **SISTER MARY THERESA MURPHY**, and **NORTON SPRITZ, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) and 230 (12) of the Public Health Law. **JANE B. LEVIN, ESQ.**, Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this Determination and Order.

SUMMARY OF THE PROCEEDINGS

Notice of Hearing dated:	April 13, 1995
Hearing dates:	April 27, 1995 May 17, 1995 May 18, 1995 May 31, 1995 June 12, 1995 June 21, 1995
Interim Report Summary Suspension:	July 7, 1995
Deliberation date:	July 19, 1995

Place of hearings:		NYS Department of Health Metropolitan Regional Office 5 Penn Plaza New York, New York
Petitioner appeared by:		Jerome Jasinski, Esq. Acting General Counsel NYS Department of Health
	By:	Terrence Sheehan, Esq. Associate Counsel
Respondent appeared by:		Wood & Scher The Harwood Building 14 Harwood Court Scarsdale, New York 10583
	By:	Anthony Scher, Esq.

WITNESSES

For the Petitioner:	Daniel Ferrara, D.O. William Reynolds Stephan Colinas, M.D.
For the Respondent:	Edward M. Birdsong, D.O. John McIvor, M.D. Ronald Paynter, M.D. Craig Smestad, M.D. Richard Pino, M.D. Fred W.Grello, M.D. Ellen Scheiner Kenneth Riley, M.D.

STATEMENT OF CHARGES

The Statement of Charges essentially charges the Respondent with professional misconduct in that he practiced with negligence, gross negligence, incompetence and gross incompetence on more than one occasion, and that he failed to maintain adequate medical records, The charges are more specifically set forth in the Statement of Charges, a copy of which is attached to and made a part of this Determination and Order.

FINDINGS OF FACT

Numbers in parentheses refer to transcript page numbers of exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence.

GENERAL FINDINGS

1. Edward Birdsong, D.O., the Respondent, is a physician who was duly licensed to practice medicine in New York State on or about November 6, 1985 by the issuance of license number 164669 by the New York State Education Department.

2. Respondent graduated from the New York College of Osteopathic Medicine in 1982 (T. 223) and thereafter spent one (1) year in a transitional residency program at St. Elizabeth Hospital Medical Center in Youngstown, Ohio, during which time he spent one (1) to two (2) month blocks in a number of medical specialties.

3. From 1983 to 1985, the Respondent, under the auspices of the Public Health Service, went into the private practice of family medicine in Port Arthur, Texas. Thereafter, he practiced in a number of family practice settings until 1987, when he joined the emergency department staff of Richmond Memorial Hospital in Staten Island, New York. (T. 228) He joined the emergency department staff of Good Samaritan Hospital in West Islip, New York in July of 1987 (T. 228) and also works at several other hospital emergency departments in Long Island, New York. (T. 229)

4. Patients A, B, C, D, E, and F were all treated by Respondent at Good Samaritan Hospital, West Islip, New York.

FINDINGS OF FACT AS TO PATIENT A

5. Patient A, an 82 year old male, came by ambulance to the emergency department on January 18, 1994 with a chief complaint of difficulty breathing. He was treated and discharged by the Respondent on that day. (Pet. Ex. 2)

6. Respondent's medical history of Patient A does not document a clear elucidation of the nature of Patient A's shortness of breath or progression of symptoms, the reason he presented at the emergency department at the time and date, his past medical history, or an adequate history of symptoms of related disease, such as cardiac or pulmonary problems. (T. 23-26)

7. Respondent did not document an adequate physical examination of Patient A. The record of his physical examination omits an evaluation of the adequacy of Patient A's respiration, including the use of accessory muscles of respiration, whether there was an examination of his calves, and an adequate evaluation of the patient's abnormal vital signs, particularly his pulse and respiration. (T 27-28; Pet. Ex. 2)

8. Respondent ordered a chest xray. The xray demonstrated pneumonia and a possible lung mass. (T. 255, 297, 400; Pet. Ex. 14)

9. Respondent ordered an electrocardiogram for Patient A, which had abnormal results. (T. 73-74)

10. Respondent discharged the patient on Bactrim and Lasix, and with a recommendation to obtain a CAT scan. However, Respondent did not document how his interpretation of the abnormal xray and cardiogram results were integrated into the patient's management, nor his rationale for prescribing the medications. (T. 30-31, 33-35, 72; Pet. Ex. 2)

11. Patient A was admitted to Southside Hospital, Bay Shore, New York on January 22, 1994. (Pet. Ex. 3)

CONCLUSIONS AS TO PATIENT A

1. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient A.

2. Respondent failed to obtain and document an appropriate medical history.

3. Respondent failed to obtain and document an appropriate physical examination.

4. Respondent inappropriately discharged Patient A.

5. Respondent appropriately recommended a follow-up CAT scan, but failed to recognize that the immediate needs of the patient for admission to the hospital and treatment took priority over diagnostic considerations.

6. Respondent demonstrated an inability to integrate clinical data and come to a reasonable conclusion concerning the disposition of the patient.

FINDINGS OF FACT AS TO PATIENT B

12. Patient B, a 34 year old female, came to the emergency department on June 29, 1993 with a chief complaint of chest pain. She was treated and discharged by the Respondent on that day. (T. 90-91; Pet. Ex. 4)

13. On that initial visit, Respondent did not document what brought on the patient's chest pain, any associated symptoms, where the pain was located, whether it radiated anywhere else, what relieved the pain, and how often the pain occurred. Respondent also did not document whether the patient had any cardiac risk factors or possible illicit drug use. (T. 92-94)

14. Patient B's initial pulse rate was abnormal. Respondent did not document the performance of a repeat pulse rate, or whether there were physical signs of heart failure. (T. 94-95; Pet. Ex. 4)

15. Respondent ordered an electrocardiogram of Patient B, which he correctly interpreted as demonstrating inferior ischemia. (T. 95-97; Pet. Ex. 4)

16. Ischemia is a significant positive finding, which in this tracing was consistent with an acute myocardial infarction. (T. 97-98)

17. The Respondent discharged the patient. (Pet. Ex. 4)

18. The next day, June 20, 1993, on the recommendation of the staff cardiologist, the patient was recalled to the emergency department because of her abnormal electrocardiogram. On that day, the Respondent again saw the patient. He failed to document an adequate history which was relevant to the reason for the recall. (Pet. Ex. 4)

19. Respondent ordered a repeat electrocardiogram, which was abnormal. The patient's chart does not document the relationship between the first and second electrocardiograms. Respondent also ordered cardiac enzyme tests. (Pet. Ex. 4)

20. Respondent stated that he had an informal consultation with Dr. Steven Cokinas, a cardiologist, about the disposition of Patient B, and the Dr. Cokinas told him that it was alright to send the patient home. (T. 951-952)

21. Dr. Cokinas denied that he told the Respondent to send the patient home. (T. 1022)

22. The Respondent discharged the patient before the results of the cardiac enzyme tests were available. (T. 102-104, 116-117) These test results documented an acute myocardial infarction.

23. Approximately one (1) hour after the patient was discharged the second time, she was recalled to the emergency department, where she was admitted with a diagnosis of rule-out myocardial infarction. She was treated in the cardiac care unit. (T. 105-106)

CONCLUSIONS AS TO PATIENT B

7. The Respondent not only failed to meet minimally acceptable standards of medical practice in his care of Patient B, but his treatment of this patient showed a severe and *repeated* inability to integrate the clinical material and come to a reasonable conclusion about the diagnosis and care of this patient.

8. Respondent failed to obtain and document an appropriate medical history.

9. Respondent failed to perform and document an appropriate physical examination.

10. Respondent inappropriately and dangerously discharged Patient B on two (2) occasions.

FINDINGS OF FACT AS TO PATIENT C

24. Patient C, a 32 year old pregnant female, presented to the emergency department on May 30, 1993 with chief complaints of shortness of breath and pain between her shoulders. She was treated and discharged by the Respondent on that day. (T. 118; Pet. Ex. 5 and 6)

25. Respondent's history for Patient C did not document the nature and intensity of the pain, any history of trauma, the factors which exacerbated or relieved the pain, or whether any associated symptoms such as fever, cough or sputum production were present, nor was any mention made of possible pregnancy related conditions. (Pet. Ex. 5)

26. Respondent's physical examination did not document a repeat of abnormal pulse and respiration rate, nor an exam of the abdomen or extremities. (Pet. Ex. 5)

27. Respondent did not order a chest xray. (T. 120) Respondent testified that the patient refused a chest xray due to her pregnancy, but this was not documented on the chart. (T. 782; Pet. Ex. 5)

28. Respondent did not order an OB/GYN consultation. (T. 121)

29. A complete blood count and chemistry panel were ordered for this patient. They revealed a white blood count of 25,300 with 26% bands. The Respondent did not document the significance of this finding, which is grossly abnormal. (T. 122; Pet. Ex. 5)

30. One day later, Patient C returned to the emergency department and was admitted with a diagnosis of rule-out pneumonia and/or pulmonary embolus. (Pet. Ex. 6)

CONCLUSIONS AS TO PATIENT C

11. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient C.

12. Respondent failed to obtain and document an appropriate medical history.

13. Respondent failed to perform and document an adequate physical examination.

14. Respondent failed to order an OB/GYN consult for a female in her eighth month of pregnancy who was in fact seriously ill.

15. Respondent failed to order a chest xray, or to document the reason for not doing so.

16. Respondent failed to appreciate the implications of the markedly elevated white count and marked shift to the left.

17. Respondent inappropriately discharged Patient C.

18. Respondent demonstrated an inability to integrate clinical data and come to a reasonable conclusion concerning the disposition of the patient.

FINDINGS OF FACT AS TO PATIENT D

31. Patient D, a six week old male, was presented to the emergency department on December 9, 1991 with congestion and coughing, and was treated and discharged by the Respondent. (Pet. Ex. 7)

32. Respondent adequately documented the patient's history by incorporating the nurse's note with his own finding of no fever. (Pet. Ex. 7)

33. Respondent documented an adequate physical examination. (T. 744; Pet. Ex. 7)

34. Respondent ordered a chest xray, which he interpreted as negative. (T. 745, 747, 757)

35. Respondent discharged the patient with a diagnosis of bronchitis. (Pet. Ex. 7) This diagnosis is inappropriate in a child of this age. (T. 771)

36. The patient was admitted to Long Island Jewish Hospital the following day with a diagnosis of bronchiolitis. (T. 144; Pet. Ex. 7A)

CONCLUSIONS AS TO PATIENT D

19. Respondent met the minimum standards of medical care with respect to this patient.

20. Respondent's history does comport with minimally acceptable standards of record keeping, although the notation "above noted" is not the preferred method of documenting a patient's history.

21. The Respondent did perform and document an adequate physical examination.

22. Respondent correctly interpreted the chest xray.

23. It was acceptable for the Respondent to discharge Patient D, since although bronchitis is not an appropriate diagnosis for an infant, the illness did not appear to be serious in nature and the treatment rendered was acceptable.

FINDINGS OF FACT AS TO PATIENT E

37. Patient E, a 24 year old male, presented to the emergency department with a chief complaint of chest pain and difficulty breathing. He was treated and released by Respondent. (Pet. Ex. 8)

38. Respondent did not document whether the patient had a history of fever, chills, cough, trauma, shortness of breath or a productive cough. Also, the Respondent did not document whether the patient had any risk factors for immunosuppressive disease, used illicit drugs, or had any history of respiratory illness or disease. (T. 168-169; Pet. Ex. 8)

39. Respondent failed to document a physical examination of the patient's abdomen or extremities. There was no documentation of a pulse rate, or a repeat of an abnormal respiratory rate. (T. 170; Pet. Ex. 8)

40. Respondent ordered a chest xray, but incorrectly interpreted it as negative, when it in fact demonstrated a pneumonia. (T. 170-171; Pet. Ex. 12)

41. Respondent did not order any blood tests. (Pet. Ex. 8)

42. Respondent diagnosed Patient E with pleurisy and discharged him from the hospital without any prescription for antibiotics. (T. 174-175; Pet. Ex. 8)

43. Patient E returned to the hospital two (2) days later and was admitted with a diagnosis of multilobar pneumonia. (Pet. Ex. 8)

CONCLUSIONS AS TO PATIENT E

24. The Respondent failed to meet minimally acceptable standards of medical practice in his care of Patient E.

25. Respondent failed to obtain and document an appropriate medical history.

26. Respondent failed to obtain and document an appropriate physical examination.

27. Respondent mis-read Patient E's xray.

28. Respondent inappropriately diagnosed Patient E.

29. Respondent failed to prescribe appropriate antibiotics.

30. Respondent demonstrated an inability to integrate clinical data and come to a reasonable conclusion concerning the disposition of the patient.

FINDINGS OF FACT AS TO PATIENT F

44. Patient F, an 84 year old female, presented to the emergency department on March 5, 1991 via ambulance with a chief complaint of upper back pain and was treated and discharged on that day by Respondent. (T. 183; Pet. Ex. 9)

45. Respondent did not document whether Patient F had any associated symptoms, such as shortness of breath, nausea, vomiting or any radiation of pain to other areas. (T. 183-184; Pet. Ex. 9)

46. Respondent documented an adequate physical examination. (Pet. Ex. 9)

47. Respondent ordered an electrocardiogram. He noted the significant abnormalities of the results on the chart, but did not document his interpretation of their meaning, which was consistent with significant ischemia. (Pet. Ex. 9)

48. Respondent diagnosed Patient F with "back pain, etiology uncertain," and discharged her. (Pet. Ex. 9)

49. Patient F returned to the emergency department later that day and was treated by the Respondent and admitted to the hospital as an in-patient. (Pet. Ex. 9)

CONCLUSIONS OF LAW AS TO PATIENT F

31. The Respondent not only failed to meet minimally acceptable standards of medical practice in his care of Patient F, but his treatment of this patient showed a severe inability to integrate the clinical material and come to a reasonable conclusion concerning the care of this 84 year old with an abnormal EKG, who should have been admitted to the hospital.

32. Respondent failed to obtain and document an appropriate medical history.

33. Respondent obtained and documented an appropriate physical examination.

34. Respondent noted the EKG abnormalities correctly, but failed to diagnose the patient appropriately, based on this information.

35. Respondent inappropriately discharged Patient F.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous.)

FIRST SPECIFICATION:
(Practicing with negligence on more than one occasion)

SUSTAINED as to Paragraphs A and A1-4; B and B1-5; C and C1-8; E and E1, 2, 4, 6; F and F1-5.

NOT SUSTAINED as to Paragraphs D and D1-5; E3 (withdrawn) and E5.

SECOND SPECIFICATION:
(Practicing with incompetence on more than one occasion)

SUSTAINED as to Paragraphs A and A1-4; B and B1-5; C and C1-8; E and E1, 2, 4, 6; F and F1-5.

NOT SUSTAINED as to Paragraphs D and D1-5; E3 (withdrawn) and E5.

THIRD THROUGH EIGHTH SPECIFICATION:
(Practicing with gross negligence)

SUSTAINED as to Paragraphs B and B1-5; C and C1-8; F and F1-5.

NOT SUSTAINED as to Paragraphs A and A1-4; D and D1-5; E and E1, 2, 4, 5, 6; E3 withdrawn.

NINTH THROUGH FOURTEENTH SPECIFICATIONS:
(Practicing with gross incompetence)

SUSTAINED as to Paragraphs B and B1-5; F and F1-5.

NOT SUSTAINED as to Paragraphs A and A1-4; C and C1-8; D and D1-5; E and E1, 2, 4, 5, 6; E3 withdrawn.

FIFTEENTH SPECIFICATION:
(Failure to maintain an adequate medical record)

SUSTAINED as to Paragraphs A, A1, 2, 4; B, B1, 2, 5; C, C1, 2, 8; E, E1, 2, 6; F1, 5.

NOT SUSTAINED as to Paragraphs D, D1, 2, 5.

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has carefully considered all of the evidence in this matter, and unanimously determined that the Respondent was negligent and incompetent in his practice of medicine with regard to five (5) of the six (6) cases presented, grossly negligent in three (3) of the six (6), and grossly incompetent in two (2) of the six (6).

It found the State's expert witness to be highly credible, and found that since he had a similar medical education to that of Respondent (osteopathic medical school) and works as an emergency department director in a hospital in the same community as the Respondent, he was able to offer an appropriate and unbiased opinion of the care rendered in the six (6) cases at issue.

In contrast, all of the Respondent's witnesses, some of whom were also emergency department physicians in the community, were not independent. Each of the physicians who testified had some professional connection with the Respondent, and the Committee felt that the statements made by these witnesses were not completely unbiased. There was also a lack of internal consistency among the Respondent's witnesses' testimony about the care rendered by the Respondent, and the explanations of his mistakes were varied, and in fact, differed from the reasons presented by the Respondent.

The Hearing Committee also felt that there was significant evidence presented which led it to doubt the truthfulness of some of Respondent's statements, particularly his report of an informal consultation he had with Dr. Cokinas concerning Patient B and the refusal by Patient C to have a chest xray. Additionally, in view of the thousands of patients the Respondent saw each year in the emergency department, the Committee found it not credible that Respondent electively remembered a large number of minute details which were not documented, but all of which exonerated his medical decisions.

Although sufficient to qualify for licensure and practice in the State of New York, the Respondent has had minimal formal clinical training. His post-graduate training was, in fact, limited to a single year of rotating internship without a significant emergency medicine component. Other practitioners may overcome such marginal training to develop a body of knowledge and expertise as a result of continuing experience, but this has not been the case for Respondent.

In fact, the Hearing Committee found that Respondent lacked fundamental medical knowledge in some areas. But what was more disturbing was his apparent lack of ability to integrate clearly presented clinical data into an appropriate diagnosis and treatment plan for his patients. The patients' charts demonstrated this lack of logical thinking, in which the conclusions drawn by the Respondent were not supported by the clinical findings in the charts. While we agree that emergency department charts may not be as complete as other patient records, at minimum they must contain the information necessary to support the patient care decisions made, and Respondent's charts failed to pass this test.

Equally disturbing was Respondent's inability to comprehend the severity of his mistakes, to take constructive criticism about his substandard management of certain patients, and to demonstrate an ability to learn from the experience. In response to panel questions concerning the cause of his errors, Respondent tended to blame others, e.g. the patient refused an xray; the cardiologist consult told him to release a patient with a clearly abnormal electrocardiogram.

The testimony and evidence presented, demonstrating that Respondent is a caring and compassionate individual, was unchallenged. However, while these are valuable qualities in a physician, they do not outweigh medical expertise. The numerous character references submitted by physicians in Respondent's community were considered by the Committee, but these references were not in a position to adequately judge the issues raised in this hearing.

The Committee also wishes to emphasize that its decision making was based entirely on the six (6) patients at issue here. The cases contained in the quality assurance file evidence were not accorded any weight, since those cases were not included in the Statement of Charges. Further, the Committee agrees that without significant additional materials, the quality assurance cases could not be completely and fairly analyzed.

The Hearing Committee also considered the Respondent's argument that the cases contained in the Statement of Charges are not significant in view of the thousands of patients treated by Respondent which did not give rise to allegations of wrong-doing. This argument was rejected in light of the fact that Respondent's care of at least half of the patients presented was so grossly negligent that it posed significant risk of death to these individuals.

The Hearing Committee gave long and careful consideration to recommending as a penalty that the Respondent undergo evaluation and re-training at the SUNY program. However, the Committee feels that he would not benefit from this program because of the significant defects demonstrated-his lack of logical thinking, and his failure to comprehend and acknowledge the severity of his professional shortcomings. Respondent has been in practice since 1982, and testified that he has attended a number of conferences and accumulated a great deal of CME credit. Given Respondent's years of emergency department practice and post-graduate education, the types of errors made by him were shockingly elementary, and demonstrated that he doesn't seem to be able to learn from his experience.

The Hearing Committee has, therefore, unanimously determined to revoke Respondent's license. The Committee does not consider this final determination to be incompatible with its Interim Report on the Summary Suspension, annexed hereto as Appendix A. The Committee gave a great deal of thought to that decision, but it was made without having the benefit of approximately one third of the transcripts, as well as the Proposed Findings of both Petitioner and Respondent to review. At the time of its interim report, as with this final determination, the Committee tried to exert every possible consideration to Respondent, while still fulfilling its responsibility to protecting the public. The solution devised at that time, of constant monitoring of the Respondent and countersigning all of his patient charts, is obviously not a permanent solution, and therefore, the Committee determined that revocation was the only appropriate action it could take.

ORDER

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

1. Respondent's license to practice medicine in the State of New York is **REVOKED**.

DATED: New York, New York
Aug. 17 , **1995**

GERALD BRODY, M.D.
Chairperson

SISTER MARY THERESA MURPHY
NORMAN SPRITZ, M.D.

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

IN THE MATTER OF EDWARD M. BIRDSONG, D.O.	STATEMENT OF CHARGES

EDWARD M. BIRDSONG, D.O., the Respondent, was authorized to practice medicine in New York State on or about November 6, 1985 , by the issuance of license number 164669 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Patient A (all patients mentioned herein are more fully identified in Appendix A), an 82 year old male, presented to the emergency department at Good Samaritan Hospital, West Islip, New York, on or about January 18, 1994 with a chief complaint of difficulty breathing, and was treated and discharged by Respondent. Patient A was admitted to Southside Hospital, Bay Shore, New York four days later on or about January 22, 1994. In the emergency department on January 18, Respondent:

1. failed to obtain and note an appropriate history;
2. failed to obtain and note an appropriate physical examination;
3. discharged Patient A on Bactrim and Lasix, despite findings of lung infiltrate and probable mass; and gave the patient inappropriate instructions;
4. failed to sufficiently document the patient's history, examination,

diagnostic tests and treatment plan.

B. Patient B, a 34 year old female, presented to the emergency department at Good Samaritan Hospital on or about June 19, 1993 with a chief complaint of chest pain, and was treated and discharged by Respondent. Patient B was called back to the emergency department again the next day, June 20, and was treated and discharged by Respondent. Patient B was recalled to the emergency department again approximately one hour later on June 20 and was admitted as an in-patient to the hospital's cardiac care unit. Respondent:

1. failed to obtain and note an appropriate history;
2. failed to perform and note an appropriate complete physical examination;
3. improperly discharged Patient B on June 19, despite an abnormal EKG;
4. improperly discharged Patient B on June 20 before the results of a cardiac enzyme test were available, and despite a second abnormal EKG, which was unstable; and gave the patient inappropriate instructions.
5. failed to sufficiently document the patient's history, examination, diagnostic tests and treatment plan.

C. Patient C, a 32 year old pregnant female, presented to the emergency department at Good Samaritan Hospital on or about May 30, 1993 with a chief complaint of shortness of breath, and was treated and discharged by Respondent. Patient C returned to the emergency department and was admitted into the hospital two days later on or about June 1, 1993. In the

emergency department on May 30, Respondent:

1. failed to obtain and note an appropriate history;
2. failed to perform and note an appropriate physical examination;
3. failed to order a chest x-ray as indicated;
4. failed to order arterial blood gases as indicated;
5. failed to obtain an OBY/GYN consultation.
6. failed to investigate elevated white blood count and bands as indicated;
7. improperly discharged Patient C and gave her inappropriate instructions.
8. failed to sufficiently document the patient's history, examination, diagnostic tests and treatment plan.

D. Patient D, a six week old male, was presented to the emergency department at Good Samaritan Hospital on or about December 9, 1991 due to congestion and coughing, and was treated and discharged by Respondent. Patient D returned to the emergency department and was admitted to the hospital as an in-patient the next day on December 10, 1991. In the emergency department on December 9, Respondent:

1. failed to obtain and note an appropriate history;
2. failed to perform and note an appropriate physical examination;
3. failed to correctly interpret and follow-up on an abnormal chest x-ray;
4. improperly discharged Patient D and gave inappropriate instructions.

5. failed to sufficiently document the patient's history, examination, diagnostic tests and treatment plan.

E. Patient E, a 24 year old male, presented to the emergency department at Good Samaritan Hospital on or about December 22, 1991 with a chief complaint of chest pain and difficulty breathing, and was treated and discharged by Respondent. Patient E returned to the emergency department and was admitted to the hospital as an in-patient two days later on or about December 24, 1991. In the emergency department on December 22, 1991 Respondent:

1. failed to obtain and note an appropriate history;
2. failed to perform and note an appropriate physical examination;
3. failed to obtain an indicated arterial blood test gases
4. failed to correctly interpret an abnormal chest x-ray;
5. improperly discharged Patient E.
6. failed to sufficiently document the patient's history, examination, diagnostic tests, and treatment plan.

E. 3 withdrawn by Pet. 4/27/95

F. Patient F, an 84 year old female, presented to the emergency department at Good Samaritan Hospital on or about March 5, 1991 at approximately 11 a.m., via ambulance, with a chief complaint of upper back pain, and was treated and discharged by Respondent. Patient F returned to the emergency department at approximately 3:30 p.m. on the same day and was treated by Respondent and admitted into the hospital as an in-patient. At the initial visit of 11:00 a.m., Respondent:

1. failed to obtain and note a complete history;
2. failed to order cardiac enzymes;
3. misinterpreted an EKG.
4. improperly discharged Patient F despite contraindications such as abnormal EKG and elevated blood pressure;
5. failed to sufficiently document the patient's history, examination, laboratory tests, treatment plan and reasons for discharge.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(3)(McKinney Supp. 1995) by practicing the profession of medicine with negligence on more than one occasion as alleged in the facts of two or more of the following:

1. Paragraphs A and A1-A4, B and B1-B5, C and C1-C8, D and D1-D5, E and E1-E6, and/or F and F1-F5.

SECOND SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(5)(McKinney Supp. 1995) by practicing the profession of medicine with incompetence on more than one occasion as alleged in the facts of two or more of the following:

2. Paragraphs A and A1-A4, B and B1-B5, C and C1-C8, D and D1-D5, E and E1-E6, and/or F and F1-F5.

THIRD THROUGH EIGHTH SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(4)(McKinney Supp. 1995) by practicing the profession of medicine with gross negligence as alleged in the facts of the following:

3. Paragraph A and A1-A4.
4. Paragraph B and B1-B5.
5. Paragraph C and C1-C8.
6. Paragraph D and D1-D5.
7. Paragraph E and E1-E6.
8. Paragraph F and F1-F5.

NINTH THROUGH FOURTEENTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(6)(McKinney Supp. 1995) by practicing the profession of medicine with gross incompetence as alleged in the facts of the following:

9. Paragraph A and A1-A4.
10. Paragraph B and B1-B5.
11. Paragraph C and C1-C8.
12. Paragraph D and D1-D5.
13. Paragraph E and E1-E6.

14. Paragraph F and F1-F5.

FIFTEENTH SPECIFICATION

FAILURE TO MAINTAIN ADEQUATE MEDICAL RECORDS

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(32)(McKinney Supp. 1995) by failing to maintain adequate medical records, as alleged in the facts of:

15. Paragraphs A, A1, A2 and A4, B, B1, B2 and B5, C, C1, C2 and C8, D, D1, D2 and D5, E, E1, E2 and E6 and/or F, F1 and F5.

DATED: April 13, 1995
New York, New York

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct