STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 1, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Monica J. Applewhite, M.D.
5820 Main Street
Williamsville, New York 14221

Kevin C. Roe, Esq.
NYS Department of Health
ESP – Corning Tower Room 2509
Albany, New York 12237

RE: In the Matter of Monica J. Applewhite, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-88) 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required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate.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
Hedley Park Place
433 River Street-Fourth Floor
Troy, New York 12180

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:djh

Enclosure

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

COPY

In the Matter of

Monica J. Applewhite, M.D. (Respondent)

A proceeding to review a Determination by a Committee (Committee) from the Board for Professional Medical Conduct (BPMC)

Administrative Review Board (ARB)

Determination and Order No. 02-88

Before ARB Members Grossman, Lynch, Pellman, Price and Briber
Administrative Law Judge James F. Horan drafted the Determination

For the Department of Health (Petitioner): **Kevin C. Roe, Esq.**
For the Respondent: **Pro Se**

After a hearing below, a BPMC Committee determined that the Respondent committed repeated and severe instances of professional misconduct and the Committee voted to revoke the Respondent's license to practice medicine in New York State (License). In this proceeding pursuant to N.Y. Pub. Health Law § 230-c (4)(a)(McKinney's 2002), the Respondent challenges the charges against her, conduct by the Petitioner's counsel and certain rulings by the Committee. The Respondent asks the ARB to review the entire record from the hearing. After reviewing that record and the review submissions from both parties, the ARB votes to affirm the Committee's Determination on the charges and the penalty.

Committee Determination on the Charges

The proceeding commenced by a Summary Order from the Commissioner of Health, pursuant to N.Y. Pub. Health Law § 230(12)(a). The Summary Order suspended the Respondent's License, upon the Commissioner's Determination that the Respondent's practice constituted an imminent danger to the public health. The Petitioner's Statement of Charges

alleged that the Respondent violated N. Y. Educ. Law §§ 6530(2-6), (9)(c) & (20) (McKinney Supp. 2002), under the following misconduct specifications:

- practicing medicine fraudulently,
- practicing medicine with negligence on more than one occasion,
- practicing medicine with gross negligence,
- practicing medicine with incompetence on more than one occasion,
- practicing medicine with gross incompetence,
- engaging in conduct that results in a finding in an adjudicatory proceeding that the Respondent violated federal law, when that conduct also constitutes professional misconduct in New York, and,
- engaging in conduct that evidences moral unfitness.

The negligence and incompetence charges related to the obstetric care the Respondent provided to eight persons, Patients A-B and D-I. The record refers to the Patients by initials to protect privacy. The fraud and moral unfitness charges [Factual Allegations B and B.19] alleged that that the Respondent made a knowing and false alteration in the medical record for Patient B. The allegation on the federal violation alleged that the Respondent entered into a settlement with the United States Department of Health and Human Services concerning misconduct under the Social Security Act.

A hearing on the charges and the Summary Order ensued before the BPMC Committee, which rendered the Determination now on review. The ARB review addresses the Committee's Determination on the charges and penalty only, as the ARB lacks the authority to review Summary Orders [see Pub. Health Law § 230-c (1)].

On the fraud and moral unfitness charges, the Committee found that the Respondent falsely altered her office medical record for Patient B by creating a second set of progress notes and by falsely altering other entries. The Committee sustained the fraud and moral unfitness charge. The Committee also found that the Respondent agreed to pay a $45,000.00 civil penalty to the Office of the Inspector General of the United States Department of Health and Human Services in a Settlement Agreement. The Agreement settled charges that the Respondent violated Social Security Act § 1867 (COBRA Violation) by transferring a pregnancy patient between Mercy Hospital of Buffalo and Children's Hospital of Buffalo without:

- certifying that the benefits outweighed the risks,
- a physician's examination of the patient,
- providing for a safe transfer,
- contacting the second hospital to request the transfer or advise the hospital about the transfer, and,
- obtaining the second hospital's agreement to the transfer.

The Committee sustained the charge that the Respondent engaged in conduct that constituted an offense under the COBRA Legislation, which would classify the conduct at issue as "patient dumping".

On the negligence and incompetence charges, the Committee made extensive findings concerning the care for the eight Patients. The Committee determined that the Respondent failed to:

- perform appropriate follow-up on prior tests on Patients A and B,
- order and/or obtain and/or document tests on Patients A, B, D, E, F and I,
- order and/or administer proper therapy or medication to Patients A, D, H and I,
- order and/or obtain internal medicine or hematology consultations in a timely manner for Patient A,
- review laboratory reports in a timely manner for Patient A,
- monitor sugar levels for Patient B,
- admit Patients B, D, F and H for hospitalization in a timely manner,

- adequately attend Patients B, E, F, G, H and I,
- perform caesarean sections in a timely manner on Patients D and G, and,
- perform or order adequate physical examinations or evaluations on Patients F, G, H and I.

The Committee also found that the Respondent:

- performed elective surgery on Patient A through an infected surgical field,
- encouraged Patient D to push with contractions prior to full dilation,
- ordered labor induction without adequate medical justification for Patients G and I, and,
- attempted to discharge Patient I from hospital without adequate evaluation.

The Committee sustained the charges that the Respondent practiced with negligence and incompetence on more than one occasion. The Committee also determined that the Respondent practiced with gross negligence and gross incompetence in treating Patients A, B and D.

In reaching their findings, the Committee relied on expert testimony by the Petitioner's expert witness, Robert Smith, M.D., whom the Committee found credible, articulate and concise. The Committee rejected the testimony by the Respondent's expert, James Howard, M.D. The Committee found that Dr. Howard's testimony showed bias and the Committee noted that Dr. Howard failed to return for the conclusion of his cross-examination. The Committee found the failure to return for cross-examination made Dr. Howard's testimony "a nullity of law". The Committee also found little to credit in the Respondent's testimony. The Committee noted that the Respondent failed to testify concerning Patients D-I, never admitted to an error and held up poorly on cross-examination.

The Committee voted to revoke the Respondent's License. The Committee found the Respondent's care for the Patients at issue dangerous and careless in all eight cases.

Review History and Issues

The Committee rendered their Determination on March 27, 2002. This proceeding commenced on April 10, 2002, when the ARB received the Respondent's Notice requesting a

Review. The record for review contained the Committee's Determination, the hearing record, the Respondent's brief and the Petitioner's response brief. The record closed when the ARB received the response brief on May 29, 2002.

The Respondent's brief alleged that the Committee extricated her expert's testimony from the record. The Respondent asks that the ARB reconsider that testimony in the interests of justice. Next, the Respondent contests the imminent danger finding from the Commissioner's Summary Order. As to the testimony by the Petitioner's expert, Dr. Smith, the Respondent described the testimony as skewed and the Respondent stated that Dr. Smith practiced in a safe group setting. The Respondent's brief makes arguments in opposition to the Petitioner's Statement of Charges and contests the accusation that she committed fraud by altering the record for Patient B. On the COBRA Violation, the Respondent describes one of the hospitals involved in the transfer, Mercy Hospital, as a hostile environment at which she endured countless discriminatory acts. The Respondent's brief makes no reference to the penalty the Committee imposed.

In response, the Petitioner states that the Respondent's brief consists mainly of re-argument about issues that the Committee resolved at the hearing below. In reply to the Respondent's contention that someone extricated testimony from the record by the Respondent's expert, the Petitioner argues that the Committee instead rejected Dr. Howard's testimony. The Petitioner asks that the ARB defer to the Committee's judgement on expert credibility. The Petitioner also argues that the Respondent's brief introduced references to material outside the hearing record. As to the Respondent's contention relating to the COBRA Violation, the Petitioner finds it difficult to determine whether the Respondent directed her bias accusations against Mercy Hospital or the Department of Health.

Determination

The ARB has considered the record and the parties' briefs. The hearing record included the testimony by the Respondent's expert, Dr. Howard. We affirm the Committee's Determination that the Respondent engaged in professional misconduct and the Committee's Determination to revoke the Respondent's License.

In reviewing a Committee's Determination under N. Y. Pub Health Law § 230-c(4)(a), the ARB determines: whether the Determination and Penalty are consistent with the Committee's findings of fact and conclusions of law; and, whether the Penalty is appropriate and within the scope of penalties which N. Y. Pub Health Law §230-a permits. The Respondent's brief failed to address the Committee findings and conclusions or the Committee's Determination on penalty, other than to allege that the Committee extricated Dr. Howard's testimony from the record. The Respondent instead addressed the Petitioner's Statement of Charges and expert witness and the Commissioner's Summary Order. As we noted above, the ARB lacks the authority to review a Summary Order. The Summary Order has now become moot anyway, as the Committee has sustained misconduct charges and rendered a final penalty determination.

The Respondent's brief alleged incorrectly that the Committee extricated Dr. Howard's testimony from the record. Dr. Howard's testimony remained in the record and the ARB considered that testimony along with other hearing evidence. The Respondent may have become confused by the statement in the Committee's Determination that Dr. Howard's refusal to return for cross-examination made the testimony "a nullity as a matter of law" [Committee Determination page 66]. The Respondent also challenged the testimony by the Petitioner's expert, Dr. Smith.

The Committee as the fact finder constitutes the proper entity to judge witness credibility and the ARB owes the Committee deference as to that judgement. The Committee gave extensive reasons why they credited the testimony by Dr. Smith and rejected the testimony by Dr. Howard and the Respondent. Those reasons included the Respondent's failure to testify concerning Patients D-I and Dr. Howard's refusal to return to complete cross-examination. The ARB concludes that the Committee acted reasonably and acted within their authority in relying on Dr. Smith's expert testimony and in rejecting contradictory testimony by the Respondent and Dr. Howard. We hold that the testimony by Dr. Smith and the records for the Patients at issue provided preponderant evidence to prove the charges the Committee sustained concerning patient care. As we have noted, the Respondent made no comment about the Committee's findings and conclusions, but the Respondent instead challenged the underlying charges. Her challenges often amounted to attacks against the Petitioner's counsel rather than explanations about the care at issue. The Respondent's brief also contained many vague or conclusory responses to charges such as "Lack of fund knowledge" and "Gratuitous". The ARB affirms the Committee's Determination that the Respondent practiced with gross negligence, gross incompetence, negligence on more than one occasion and incompetence on more than one occasion.

At pages 9-10 of her brief, the Respondent denied that she created two patient records for Patient B and asserts that the record she initially submitted during the investigation into the cases at issue was never certified. She indicated further that the second record she submitted for Patient B contained the original progress notes for the Patient, which the Respondent found prior to submitting the second record to the investigators. The Committee rejected the Respondent's

explanation and found the Respondent practiced fraudulently and engaged in conduct that evidenced moral unfitness.

In order to sustain a charge that a licensee practiced medicine fraudulently, a hearing committee must find that (1) a licensee made a false representation, whether by words, conduct or by concealing that which the licensee should have disclosed, (2) the licensee knew the representation was false, and (3) the licensee intended to mislead through the false representation, Sherman v. Board of Regents, 24 A.D.2d 315, 266 N.Y.S.2d 39 (Third Dept. 1966), aff'd, 19 N.Y.2d 679, 278 N.Y.S.2d 870 (1967). A committee may reject a licensee's explanation for conduct, Matter of Brestin v. Comm. of Educ., 116 A.D.2d 357, 501 N.Y.S.2d 923 (Third Dept. 1986).

In their conclusions on the fraud and moral unfitness charges, the Committee held that two sets of charts for Patient B and the alteration of those charts proved the charges. The Committee inferred that the Respondent's inability to explain discrepancies in the charts constituted a lie trying to cover another lie. The ARB holds that the Committee again acted within their authority in rejecting the Respondent's explanation and relying on other information in the record. We affirm the Committee's Determination that the two charts for Patient B showed an alteration with intent to deceive and demonstrated that the Respondent committed fraud in practice and engaged in conduct that evidenced moral unfitness.

The Committee also held that the Respondent entered into a Settlement on the COBRA Violation in a Federal Adjudicatory proceeding for conduct that would constitute professional misconduct in New York. The Respondent's brief argues ignorance about the COBRA Legislation that prohibited "patient dumping". The Respondent also argued that such violations by other physicians went unreported and that the Respondent suffered from bias and a hostile

environment at Mercy Hospital. The ARB affirms the Committee's Determination that the COBRA Violation constituted a federal statutory violation that also constituted misconduct in New York. Such conduct made the Respondent liable for disciplinary actions against her License under Educ. Law § 6580(9)(c). The ARB finds the Respondent's arguments on the issue unconvincing. The Respondent entered into a Settlement in which she agreed to pay $45,000.00 for the Violation. We refuse to allow the Respondent to re-open the COBRA Violation after she entered into the Settlement Agreement.

The Committee voted to revoke the Respondent's License. The Respondent's brief made no challenge to that penalty. The ARB may substitute our judgement for that of the Committee, in deciding upon a penalty, Matter of Bogdan v. Med. Conduct Bd. 195 A.D.2d 86, 606 N.Y.S.2d 381 (3rd Dept. 1993) and we may substitute that judgement on our own motion, Matter of Kabnick v. Chassin, 89 N.Y.2d 828 (1996). We considered whether the Committee imposed an appropriate penalty in this case on our own motion. We hold that the Committee acted appropriately in revoking the Respondent's License.

The ARB considered whether any retraining course would aid the Respondent. The Committee found the Respondent practiced with incompetence in each Patient's case at issue in this proceeding. Retraining could correct incompetence, but retraining provides no benefit to a physician who practices carelessly and fraudulently. The Committee found the Respondent careless and fraudulent. The Committee also held that the Respondent showed no remorse for her conduct. The ARB holds that the failure to recognize the need to correct her practice errors would make the Respondent a poor candidate for retraining.

The ARB also considered whethr a restricted group practice arrangement might correct the negligence and carelessness in the Respondent's practice. We considered whether the

Respondent's problems may have resulted in part from her solo practice. The ARB, however, has no jurisdiction to order a group practice to accept the Respondent as a partner. We also considered that the Respondent's problems may have resulted from treating a high risk patient population and we considered limiting the Respondent's License to forbid her from treating high risk patients. We found that alternative unworkable due to difficulty in defining high risks patients. We also concluded that the most low risk patient can become high risk at a change or deterioration in the patient's condition. The ARB also considered that the Respondent committed fraud by altering the record for Patient B. Other than revocation, a severe penalty such as a fine or a suspension could provide a sufficient penalty for fraud, to deter the Respondent and others from future misconduct. The COBRA Violation Settlement, however, resulted in a heavy fine against the Respondent and the Committee found that the Respondent failed to change her ways following that heavy fine [Committee Determination page 65].

The Respondent has practiced with negligence and incompetence repeatedly and egregiously. She has committed fraud and she has failed to show remorse for her errors. She has demonstrated that she has learned nothing from past penalties for misconduct. We conclude that the Respondent presents a danger to repeat her misconduct if we allow the Respondent to remain in medical practice and we see no workable limitation on the Respondent's practice that would protect the public. The ARB votes unanimously to revoke the Respondent's License.

ORDER

NOW, with this Determination as our basis, the ARB renders the following **ORDER:**

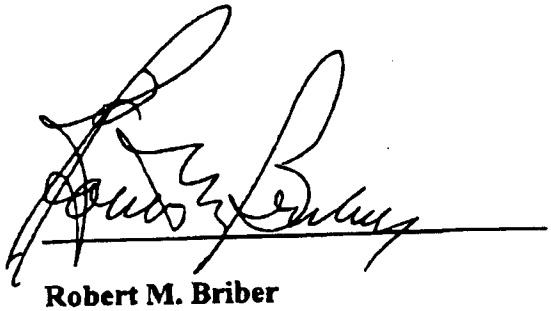
1. The ARB affirms the Committee's Determination that the Respondent committed professional misconduct.
2. The ARB affirms the Committee's Determination to revoke the Respondent's License.

Robert M. Briber
Thea Graves Pellman
Winston S. Price, M.D.
Stanley L. Grossman, M.D.
Therese G. Lynch, M.D.

In the Matter of Monica J. Applewhite, M.D.

Robert M. Briber, an ARB Member, concurs in the Determination and Order in the Matter of Dr. Applewhite.

Dated: July 2, **2002**



Robert M. Briber

In the Matter of Monica J. Applewhite, M.D.

Thea Graves Pellman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Applewhite.

Dated: 7/29, **2002**

Thea Graves Pellman

In the Matter of Monica J. Applewhite, M.D.

Winston S. Price, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Applewhite.

Dated: _____, **2002**

Winston S. Price, M.D.

In the Matter of Monica J. Applewhite, M.D.

Stanley L. Grossman, an ARB Member concurs in the Determination and Order in the Matter of Dr. Applewhite.

Dated: 06/28, 2002

Stanley L Grossman M.D.

Stanley L Grossman, M.D.

In the Matter of Monica J. Applewhite, M.D.

Therese G. Lynch, M.D., an ARB Member concurs in the Determination and Order in the Matter of Dr. Applewhite.

Dated: July 29, **2002**

Therese G. Lynch M.D

Therese G. Lynch, M.D.